DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF REMOVAL OF CONDITIONAL LICENSE

Electronic Delivery

May 18, 2023

Licensee
Scandia Capital Partners, LLC
102 North 58th Avenue West
Duluth, MN 55807

RE: Initial License Number 408476
Health Facility Identification Number (HFID) 30495
Project Number(s) SL30495015 and HL304955691C

Dear Licensee:

On May 8-9, 2023, The Minnesota Department of Health (MDH) completed a follow-up survey and a follow-up complaint investigation of your facility to determine correction of orders found not corrected on the follow-up survey and follow-up complaint investigation completed March 15, 2023, and monitoring visits completed February 2-5, 2023, and December 30, 2022, pursuant to the licensing survey and complaint investigation completed on December 7, 2022.

As a result of this follow-up survey and follow-up complaint investigation, the Department of Health 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.

Based on these findings, the condition(s) on the license were removed effective May 12, 2023.

However, this follow-up survey and follow-up complaint investigation determined your facility had not fully corrected all of the state correction orders issued pursuant to the December 7, 2022, survey and complaint investigation.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a), state correction orders found not corrected at the time of the follow-up survey and follow-up complaint investigation completed on March 15, 2023, and/or subject to a penalty assessment are as follows:

0680-Disaster Planning And Emergency Preparedness-144g.42 Subd. 10 - $500.00
1380-Training And Evaluation Of Unlicensed Personn-144g.61 Subd. 2 (b)
1620-Initial Reviews, Assessments, And Monitoring-144g.70 Subd. 2 (c-E)
1760-Documentation Of Administration Of Medication-144g.71 Subd. 8 (e)

The details of the violations noted at the time of this follow-up survey and follow-up complaint investigation completed on May 9, 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, **the total amount you are assessed is $500.00**. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
Per 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).

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

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 MDH 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.

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

Sincerely,

Maria King, RN
Division Director

Minnesota Department of Health
Health Regulation Division

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30495	A. BUILDING: _____ B. WING _____	R 05/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCANDIA CAPITAL PARTNERS LLC	102 NORTH 58TH AVENUE WEST DULUTH, MN 55807

(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 In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been 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: Project SL30495015 On May 8, 2023, through May 9, 2023, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on December 7, 2022, monitoring call on December 30, 2022, monitoring visit dated February 5, 2023, and a revisit on March 15, 2023. At the time of the survey, there were six (6) receiving services under the Assisted Living with Dementia Care license. As a result of the revisit, the following orders were reissued or issued. In addition, on May 8, 2023 a revisit was completed to verify correction of orders (1760) issued for complaint HL304955691C. As a result of this revisit, tag identification 1760 was found not corrected, and reissued.	{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 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.	

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{0 680}	Continued From page 1	{0 680}		
{0 680} SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop an emergency preparedness plan (EPP) with all required content, or practice and document testing of the plan at least twice annually as required. This had the potential to affect all residents, staff, and visitors of the facility. This practice resulted in a level two violation (a	{0 680}		

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{0 680}	Continued From page 2 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 May 8, 2023, at 10:00 a.m., the surveyor reviewed the licensee's Emergency Plan revised April 23, 2023, with executive director (ED)-J. ED-J confirmed the licensee's EPP lacked the following required content. The licensee's EPP provided did not include the following: - development of policies/procedures to address: - procedure for tracking staff and residents; and - a medical record documentation system to preserve resident information, security, and availability. - a communication plan that included: - primary and alternative means for communicating with facility staff, federal, state, regional and local emergency management agencies; - a method of sharing information and medical documentation for residents; - a means to provide information regarding the facility's needs, and its ability to provide assistance to include information about their occupancy; and - a method of sharing information from the EPP with residents and their families. The licensee's Emergency Plan policy revised	{0 680}		

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{0 680}	Continued From page 3 March 30, 2023, indicated the licensee's assisted living director was responsible for maintaining an effective and current emergency preparedness plan and implementing procedures. No further information was provided.	{0 680}		
{01380} SS=D	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency evaluations included all the required training for one of three employees (unlicensed personnel (ULP)-G). 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	{01380}		

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{01380}	Continued From page 4 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 in a limited number of locations). The findings include: ULP-G was hired on September 6, 2022, to provide direct care services under the licensee's assisted living with dementia care license. R1's February and March 2023, medication administration records (MAR) indicated ULP-G had administered R1's morning medications on several occasions. ULP-G's employee record lacked evidence ULP-G had received the following training and demonstrated competency: - safe transfer techniques and ambulation;*and - range of motioning and positioning. * (* denotes skills requiring competency testing) On May 5, 2023, at 10:00 a.m., executive director (ED)-J confirmed ULP-G had not completed the training and demonstrated competency as indicated above. The licensee's Staffing Competency policy dated August 1, 2021, indicated training and competency evaluations for all unlicensed personnel include the following. Unlicensed personnel may not work for [facility name] until they have successfully passed the written competency test (at 80%) and demonstration competency evaluation. - basic knowledge of body functioning and	{01380}		

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{01380}	Continued From page 5 changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; - reading and recording temperature, pulse, and respirations of the resident; - recognizing physical, emotional, cognitive, and developmental needs of the resident; - safe transfer techniques and ambulation; - range of motioning and positioning; and - administering medications or treatments as required. No further information was provided.	{01380}		
{01620} SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a	{01620}		

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{01620}	Continued From page 6 facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a registered nurse (RN) completed an assessment of one of one resident's skin (R4). 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: R4's May 2023, Treatment Record indicated on May 5, 2023, wound care R (right) medial thigh. Cleanse area with wound cleanser, pat dry, and apply Mepilex dressing. Change dressing every 7 (seven) days and PRN (as necessary) for soiling or falling off. Unlicensed personnel (ULP)-N performed wound care on May 6, 2023. R4's prescriber orders dated May 5, 2023, included R medial thigh, cleanse area with wound cleanser, pat dry, apply Mepilex. Change every 7 (seven) days and PRN for soiling and falling off. R4's record lacked evidence a RN assessed the wound of R4's R medial Thigh. On May 5, 2023, at 9:30 a.m. RN-O stated she was not aware R4 had a wound on R4's R medial	{01620}		

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{01620}	Continued From page 7 thigh. RN-O confirmed R4's record lacked an RN assessment of the wound on R4's thigh. The licensee's Assessment- Comprehensive Services policy dated August 1, 2021, indicated ongoing client monitoring and reassessment must be conducted as needed based on changes in the needs of the client, but cannot exceed 90 days. No further information was provided.	{01620}		
{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 as prescribed for one of two residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or	{01760}		

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{01760}	Continued From page 8 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's diagnoses included atrial fibrillation, and chronic kidney disease. R1's service plan dated August 2, 2021, indicated services included medication administration. R1's prescriber's orders dated June 30, 2022, and March 2, 2023, included metoprolol (treat atrial fibrillation) 100 mg (milligrams) one tablet every morning. R1's May 2023 medication administration record (MAR) indicated do not administer metoprolol 100 mg if R1's pulse was below 60. R1's May 2023 MAR indicated R1's Metoprolol was administered on the following dates when R1's pulse was below 60: -May 1, 2023, pulse 49; -May 2, 2023, pulse 53; and -May 3, 2023, pulse 51. On May 5, 2023, at 9:30 a.m., registered nurse (RN)-O confirmed R1's metoprolol was administered as indicated above. RN-O stated R1's metoprolol should have been held when R1's pulse was below 60. No further information was provided.	{01760}		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF EXTENDED CONDITIONAL LICENSE AND SURVEY RESULTS

Electronically Delivered
March 20, 2023

Licensee
Scandia Capital Partners LLC
102 North 58th Avenue West
Duluth, MN 55807

RE: Conditional License Number 408476
Health Facility Identification Number (HFID) 30495
Project Number(s) SL30495015 and HL304955691C

Dear Licensee:

The Minnesota Department of Health (MDH) completed a follow-up evaluation on March 15, 2023, to determine correction of orders found not corrected during the monitoring visits completed on February 2 - 5, 2023 and December 30, 2022, pursuant to the licensing evaluation completed on December 7, 2022. This follow-up evaluation determined your facility continues not to be in substantial compliance with state licensing orders pursuant to the laws of Minnesota Statutes, Chapter 144G.

Please Note: A complaint evaluation (HL304955691C) was completed on December 7, 2022, however the results were not noted in tag 000 (initial comments). Investigation of complaint (HL304955691C) resulted in tag identifications 0495 and 1760 being issued. This follow-up evaluation determined tag identification 0495 was corrected, however tag identification 1760 was not corrected and reissued.

As a result, MDH is extending the conditional license 60-days, due to expire on **May 19, 2023**.

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

IMPOSITION OF FINES
In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and imposed immediately with no opportunity to correct the violation first as follows:

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

In accordance with Minn. Stat. § 144G.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The Department of Health also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5)(b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

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

St - 0 - 0250 - 144g.20 Subdivision 1 - Conditions - $500.00
St - 0 - 0430 - 144g.40 Subd. 2 - Uniform Checklist Disclosure Of Services
St - 0 - 0630 - 144g.42 Subd. 6 (b) - Compliance With Requirements For Reporting Ma
St - 0 - 0650 - 144g.42 Subd. 8 - Employee Records
St - 0 - 0660 - 144g.42 Subd. 9 - Tuberculosis Prevention And Control
St - 0 - 0680 - 144g.42 Subd. 10 - Disaster Planning And Emergency Preparedness - $500.00
St - 0 - 0730 - 144g.43 Subd. 3 - Contents Of Resident Record
St - 0 - 0810 - 144g.45 Subd. 2 (b)-(f) - Fire Protection And Physical Environment - $500.00
St - 0 - 1370 - 144g.61 Subd. 2 (a) - Training And Evaluation Of Unlicensed Personn
St - 0 - 1380 - 144g.61 Subd. 2 (b) - Training And Evaluation Of Unlicensed Personn
St - 0 - 1420 - 144g.62 Subd. 2 - Delegation Of Assisted Living Services
St - 0 - 1620 - 144g.70 Subd. 2 (c-E) - Initial Reviews, Assessments, And Monitoring
St - 0 - 1650 - 144g.70 Subd. 4 (f) - Service Plan, Implementation And Revisions To - $500.00
St - 0 - 1750 - 144g.71 Subd. 7 - Delegation Of Medication Administration - $3,000.00
St - 0 - 1760 - 144g.71 Subd. 8 - Documentation Of Administration Of Medication
St - 0 - 1790 - 144g.71 Subd. 10 - Medication Management For Residents Who Will
St - 0 - 2040 - 144g.81 Subdivision 1 - Fire Protection And Physical Environment -$500.00
St - 0 - 2170 - 144g.84 - Services For Residents With Dementia - $500.00

The total amount you are assessed is $6,000.00. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

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

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

Please address your cover letter for reconsideration requests to:

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

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.

CONDITIONAL LICENSE ISSUED:
MDH will issue Scandia Capital Partners LLC a conditional assisted living facility license for an additional 60 calendar days from the date of this notice. At an unannounced point in time, within the 60 calendar days, MDH will conduct a follow-up evaluation, as defined in Minn. Stat. § 144G.30, Subd. 6. Based on the results of the follow-up evaluation, MDH will determine if Scandia Capital Partners LLC is in substantial compliance.

The following conditions will remain in effect through the extended conditional license period and apply to the conditional assisted living facility license:

a. **No new substantiated maltreatment allegations:** If any new investigations begin in the conditional license period, and the allegations are substantiated, MDH may pursue additional enforcement actions up to and including immediate temporary suspension and revocation of the license.

b. **No new admissions:** Scandia Capital Partners LLC will not admit any new residents under its conditional assisted living facility license until the MDH removes the “no new admissions” condition.

c. **Consultant:** Scandia Capital Partners LLC will continue to contract with an RN to provide consultation concerning all resident(s) to whom Scandia Capital Partners LLC provides licensed assisted living services under the conditional license. The consultant must continue to have access to all resident(s) receiving services from Scandia Capital Partners LLC. The consultant will continue to conduct initial and ongoing evaluations of the provider. Direct resident observation may be required based on the consultant’s judgement or at the discretion of MDH. Scandia Capital Partners LLC will continue to be responsible for the expense of the contract with the RN. The main purpose of the consultant is to continue to provide guidance to Scandia Capital Partners LLC in an effort to help Scandia Capital Partners LLC align their practices with the requirements of Minn. Stat. §§ 144G.01 – 144G.9999 and to provide oral and written reports to MDH noting

progress toward substantial compliance and/or concerns about observations. Scandia Capital Partners LLC will continue to develop and implement policies, procedures, and processes specific to the offered services in accordance with the guidance provided by the consultant to ensure ongoing monitoring and substantial compliance with statutory requirements.

d. Reports: The RN consultant will continue to provide MDH with regular reports. The reports will continue on a weekly basis until MDH notifies Scandia Capital Partners LLC and the RN consultant about a change. Each report will continue to be electronically submitted to Jessica Chenze, Evaluator Supervisor, State Evaluation Team, Health Regulation Division, at jessica.chenze@state.mn.us. Jessica Chenze can be reached at 218-332-5175 (office) with questions about reports. The content of the reports will continue to include information such as:

i. Progress towards correction of licensing orders;
ii. Observations of staff delivering assisted living services and the level of competency observed;
iii. Conversations with residents and family members about satisfaction with assisted living services;
iv. Conversations with staff about their level of knowledge about the tasks they perform, the people they serve and the health professionals who delegate to them;
v. Overall impressions about the quality of the assisted living services delivered;
vi. Overall impressions about the dignity with which the residents and their family members are treated;
vii. Concerns; and
viii. Any other information requested by the Department or considered important by the RN consultant(s).

e. Monitoring visits: MDH may make unannounced monitoring visits to assess the progress of Scandia Capital Partners LLC to correct the violations cited during the evaluation as well as to determine the overall practice of Scandia Capital Partners LLC in meeting the needs of the people it serves. In addition, the Office of Ombudsman for Long-Term Care (OOLTC) may also make unannounced monitoring visits to determine the level of satisfaction of those people who receive licensed assisted living services. The OOLTC will share their findings with MDH.

f. Follow-up Evaluation: At the time of the follow-up evaluation, MDH may pursue additional enforcement actions, up to and including immediate temporary suspension or revocation of the license if MDH identifies any level 3 or 4 violations or widespread care related violations.

g. **Corrective Action Plan:** Scandia Capital Partners LLC will continue to develop and work within a corrective action plan (CAP). The CAP is a working document that includes at least the following information:
    i. A statement of the concern
    ii. A description of what will happen to correct the concern
    iii. A target date for when each correction will be complete
    iv. Who is responsible to make sure it happens
    v. Current status of correction work
    vi. Description of a plan to monitor and ensure ongoing substantial compliance for each corrected order

RESULTS OF FOLLOW-UP EVALUATION DURING THE CONDITIONAL LICENSE PERIOD:
MDH will determine if Scandia Capital Partners LLC is in substantial compliance based on the results of the follow up evaluation. MDH will make this determination within the extended 60-day conditional license period. If MDH determines Scandia Capital Partners LLC is in substantial compliance on the follow up evaluation, MDH will remove the conditions from Scandia Capital Partners LLC's assisted living facility license, and Scandia Capital Partners LLC will correct violations identified during the evaluation to come into substantial compliance. If MDH determines Scandia Capital Partners LLC is not in substantial compliance, MDH may take additional enforcement action against Scandia Capital Partners LLC, including placement of additional conditions, issuing a second conditional license, or employ any of the enforcement tools listed in Minn. Stat. § 144G.20 up to and including immediate temporary suspension and revocation.

REQUESTING A HEARING:
Pursuant to Minn. Stat. §144G.20, Subd. 17 (c), the licensee may appeal an order immediately temporarily suspending a license or issuing a conditional license. The appeal must be made in writing by certified mail or personal service. If mailed, the appeal must be postmarked and sent to the commissioner within five calendar days after the license holder receives notice. If an appeal is made by personal service, it must be received by the commissioner within five calendar days after the license holder received the order. The request for hearing should be addressed to:

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

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this notice and the results of this visit with the President of your organization's Governing Body.

If you have any questions, please contact Jessica Chenze directly at: 218-332-5175.

Sincerely,

Maria King, RN
Division Director

Minnesota Department of Health
Health Regulation Division

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30495	A. BUILDING: _____ B. WING _____	R 03/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCANDIA CAPITAL PARTNERS LLC	102 NORTH 58TH AVENUE WEST DULUTH, MN 55807

(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 In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been 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: Project SL30495015 On March 14, 2023, through March 15, 2023, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on December 7, 2022, monitoring call on December 30, 2022, and monitoring visit dated February 5, 2023. At the time of the survey, there were six (6) receiving services under the Assisted Living with Dementia Care license. As a result of the revisit, the following orders were reissued. Immediate correction order was identified on March 14, 2023, issued for SL#30495015015, tag identification 1750. Immediacty of correction order 1750 was removed on March 15, 2023, however, noncomplaince remained at a scope and level G.	{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 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.	

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{0 000}	Continued From page 1 Please Note: At the time of the December 7, 2022 survey, a complaint investigation was also completed, however it was not noted in tag 000 (initial comments). Investigation of complaint HL304955691C resulted in tag identifications 0495 and 1760 being issued. In addition, on March 15, 2023 a revisit was completed to verify correction of orders (0495 and 1760) issued for complaint HL304955691C. As a result of this revisit, tag identification 0495 was found corrected and tag identificatoin 1760 was found not corrected, and reissued.	{0 000}		
{0 250} SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department	{0 250}		

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{0 250}	Continued From page 2 access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4, or interferes with or impedes access by the Office of Ombudsman for Mental Health and Developmental Disabilities according to section 245.94, subdivision 1; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to show they met the requirements of licensure, by attesting the managerial officials who oversaw the day-to-day operations understood applicable statutes and rules; nor	{0 250}		

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{0 250}	Continued From page 3 developed and/or implemented current policies and procedures as required with records reviewed. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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: During the entrance conference on March 14, 2023, at 8:15 a.m. executive director (ED)-J, licensed assisted living director (LALD)-D, and registered nurse consultant (RNC)-K stated they were familiar with the assisted living regulations and the licensee provided medication and treatment management services. The licensee's Application for Assisted Living License, section titled Official Verification of Owner or Authorized Agent, (page four and five of the application), identified, I certify I have read and understand the following: [a check mark was placed before each of the following]: - I have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section] 144G.45, my building(s) must comply with subdivisions 1-3 of the section, as applicable section Laws 2020, 7th Spec. [special] Sess [session]., chpt. [chapter] 1. art. [article] 6, sect. 17.	{0 250}		

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{0 250}	Continued From page 4 - I have read and fully understand Minn. Stat. sect. 144G.80, 144G.81. and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22, my building(s) must comply with these sections if applicable. - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G. - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659. - Reporting of Maltreatment of Vulnerable Adults. - Electronic Monitoring in Certain Facilities. - I understand pursuant to Minn. Stat. sect. 13.04 Rights of Subjects of Data, the Commissioner will use information provided in this application, which may include an in-person or telephone conference, to determine if the applicant meets requirements for assisted living licensing. I understand I am not legally required to supply the requested information; however, failure to provide information or the submission of false or misleading information may delay the processing of my application or may be grounds for denying a license. I understand that information submitted to the commissioner in this application may, in some circumstances, be disclosed to the appropriate state, federal or local agency and law enforcement office to enhance investigative or enforcement efforts or further a public health protective process. Types of offices include Adult Protective Services, offices of the ombudsmen, health-licensing boards, Department of Human Services, county or city attorneys' offices, police, local or county public health offices. - I understand in accordance with Minn. Stat.	{0 250}		

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{0 250}	Continued From page 5 sect. 144.051 Data Relating to Licensed and Registered Persons (opens in a new window), all data submitted on this application shall be classified as public information upon issuance of a provisional license or license. All data submitted are considered private until MDH issues a license. - I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659 governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. - I have examined this application and all attachments and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct, and complete. I will notify MDH, in writing, of any changes to this information as required. - I attest to have all required policies and procedures of Minn. Stat. chapter 144G and Minn. Rules chapter 4659 in place upon licensure and to keep them current as applicable. Page five was electronically signed by RD/LPN-D on May 12, 2022. The licensee had an assisted living license issued on August 1, 2022, with an expiration date of April 30, 2023.	{0 250}		

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{0 250}	Continued From page 6 The licensee failed to ensure the following policies and procedures were implemented: (1) orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; (2) conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate; (3) conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards; (4) medication and treatment management; (5) delegation of tasks by registered nurses or licensed health professionals; On March 15, 2023, at 10:00 a.m., ED-J stated they failed to implement the following policies: reporting of maltreatment of vulnerable adults, training, and competency evaluations of staff, conducting initial evaluations of residents' needs and the providers' ability to provide those services, conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, medication and treatment management, delegation of tasks by registered nurses, and failed to implement corresponding policies and procedures, as required. As a result of this survey, the following orders were issued 0250, 0430, 0630, 0650, 0660, 0680, 0730, 0810, 1370, 1380, 1420, 1620, 1650,	{0 250}		

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{0 250}	Continued From page 7 1750, 1760, 1790, 2040, and 2170, indicating the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.08 to 144G.95. No further information was provided.	{0 250}		
{0 430} SS=C	144G.40 Subd. 2 Uniform checklist disclosure of services (a) All assisted living facilities must provide to prospective residents: (1) a disclosure of the categories of assisted living licenses available and the category of license held by the facility; (2) a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and (3) an oral explanation of the services offered under the contract. (b) The requirements of paragraph (a) must be completed prior to the execution of the assisted living contract. (c) The commissioner must, in consultation with all interested stakeholders, design the uniform checklist disclosure form for use as provided under paragraph (a). This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a copy of the uniform checklist disclosure of services (UDALSA) with the required content for two of two residents (R1, R4).	{0 430}		

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{0 430}	Continued From page 8 This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 R1's diagnoses included atrial fibrillation, and chronic kidney disease. R1's service plan dated August 2, 2021, indicated the resident received the following services: medication administration, assistance with shower, dressing, grooming, laundry housekeeping and safety checks every two (2) hours. R4 R4's diagnoses included hypothyroidism, and hypertension. R's service plan dated February 9, 2022, indicated the resident received the following services: medication administration, assistance with showers, housekeeping, laundry and safety checks every two (2) hours. R1 and R4's record lacked evidence the resident received a copy of the licensee's UDALSA to include: - a disclosure of the categories of assisted living licenses available and the category of license held by the facility; and - a written checklist listing all services permitted	{0 430}		

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{0 430}	Continued From page 9 under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide. On March 14, 2023, at 8:15 a.m., registered nurse consultant (RNC)-K stated the UDALSA had not been provided to R1, R4, and all the other residents receiving services under the licensee's assisted living with dementia care license. No further information was provided.	{0 430}		
{0 630} SS=E	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop an individual abuse prevention plan with all required content for two of two residents (R1, R4). This practice resulted in a level two violation (a	{0 630}		

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{0 630}	Continued From page 10 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1 R1's diagnoses included atrial fibrillation, CAD (coronary artery disease) and chronic kidney disease. R1's March 2023 care plan indicated R1 received assistance with medication administration, bathing, dressing, grooming, laundry and housekeeping. R1's Vulnerability Assessment dated February 10, 2023, indicated R1 was vulnerable in the following areas, oriented to person, place, and time; environment safe/clean; unable to follow instructions; ability to use the telephone; social support system; and ability to report abuse/neglect concerns. The Vulnerability Assessment indicated to complete an Individual Abuse Prevention Plan for all areas marked "Yes". A plan to minimize the risk of abuse/neglect may also be established in the Care plan for each vulnerable area identified in this assessment. R1's Vulnerability Assessment dated February 10, 2023, and R1's Care Plan for March 2023, did not include a plan to minimize the risk of abuse/neglect for each vulnerable area identified	{0 630}		

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{0 630}	Continued From page 11 in the Vulnerability Assessment. R4 R4's diagnoses included hypothyroidism, and hypertension. R4's March 2023 Care Plan indicated R4 received assistance with medication administration, bathing, housekeeping, and laundry. R4's Vulnerability Assessment dated February 14, 2023, indicated R4 was vulnerable in the following areas, environment safe/clean; visual difficulties, understands/follow instructions, able to ambulate safety with/without device; and ability to report abuse/neglect concerns. The Vulnerability Assessment indicated to complete an Individual Abuse Prevention Plan for all areas marked "Yes". A plan to minimize the risk of abuse/neglect may also be established in the Care Plan for each vulnerable area identified in this assessment. R4's Vulnerability Assessment dated February 14, 2023, and R4's Care Plan for March 2023, did not include a plan to minimize the risk of abuse/neglect for each vulnerable area identified in the Vulnerability Assessment. On March 14, 2023, at 2:00 p.m. registered nurse consultant (RNC)-K stated R1 and R4's Vulnerability Assessment and Care Plans did not include a plan to minimize the risk of abuse/neglect for each vulnerable area identified in the Vulnerability Assessment. The licensee's Assessment - Comprehensive Services policy, dated August 1, 2021, indicated an individualized initial evaluation of all new	{0 630}		

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{0 630}	Continued From page 12 clients shall be completed on admission by a registered nurse (RN) in order to develop a personalized service plan. The policy directed the RN will provide the admission visit and conduct assessment, including a vulnerability assessment. The policy did not describe content of the vulnerability assessment. No further information was provided.	{0 630}		
{0 650} SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by:	{0 650}		

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{0 650}	Continued From page 13 Based on interview and record review, the licensee failed to ensure employee records included a job description with all for the required content for one of three employees (unlicensed personnel (ULP)-G). 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 in a limited number of locations). The findings include: ULP-G's employee records lacked a job description. ULP-G was hired on September 6, 2022, to provide direct care under the licensee's assisted living with dementia care license. R1's February and March 2023, medication administration records (MAR) indicated ULP-G had administered R1' morning medications on several occasions. On March 14, 2023, at 11:30 a.m., licensed assisted living director (LALD)-D stated ULP-G was given a new job description to sign, but has not returned it. No further information was provided.	{0 650}		

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{0 660}	Continued From page 14	{0 660}		
{0 660} SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC). The licensee failed to ensure a TB history and symptom screen were completed for one of three employees (unlicensed personnel (ULP)-G) and screening for active TB (either a two-step tuberculin skin test (TST) or blood test) were completed and documented for one of three employees (ULP-G). 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	{0 660}		

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{0 660}	Continued From page 15 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 in a limited number of locations). The findings include: ULP-G was hired on September 6, 2022, to provide direct care services under the licensee's assisted living with dementia care license. R1's February and March 2023, medication administration records (MAR) indicate ULP-G had administered R1' morning medications on several occasions. ULP-G's employee record lacked evidence a TB history and symptom screen and TST had been completed. On March 14, 2023, at 11:30 a.m., licensed assisted living director (LALD)-D stated ULP-G's employee record lacked proper documentation of a completed a TB history and symptom screen and TST. LALD-D stated ULP-G had a TB screen but was unsure of what type and has been trying to request information from the physician. The licensee's Tuberculosis Screening/Prevention policy dated August 1, 2021, indicated [facility name] will observe the recommended precautions related to TB prevention as identified by the Centers for Disease Control and Prevention (CDC) and the Minnesota Department of Health (MDH). The precautions include the following elements: -Frequency of Screening; and -Serial Testing.	{0 660}		

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{0 660}	Continued From page 16 No further information was provided.	{0 660}		
{0 680} SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop an emergency preparedness plan (EP) with all required content or practice and document testing of its plan at least twice annually as required. This had the potential to affect all six (6) residents, staff and	{0 680}		

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{0 680}	Continued From page 17 visitors of the facility. 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: During the entrance conference on March 14, 2023, at 8:15 a.m., the evaluator requested to view the facility's emergency plan and related documentation, which was later provided. On March 14, 2023, at 2:00 p.m., executive director (ED)-J provided the licensee's Emergency Plan revised February 28, 2023. ED-J stated the Emergency Plan was not completed. ED-J stated they still needed contracts signed with a transportation company and a temporary shelter until the emergency has resided. The licensee's emergency preparedness plan lacked the following components: -description of the population served by licensee; -process for emergency preparedness cooperation with state and local EP officials/organizations; -subsistence needs for staff and residents during emergency situation; -procedure for tracking staff and residents; -development of all policies/procedures, based on assessment; and additional policies for: -sheltering in place; -handling and use of volunteers; -arrangement with other faculties (including sister	{0 680}		

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{0 680}	Continued From page 18 facilities); -development of a communication plan, including primary and alternate means for communication; -methods for sharing information; -EP training and testing program; -EP training program for staff (including documentation of training provided); and -annual EP testing requirements. No further information was provided.	{0 680}		
{0 730} SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to	{0 730}		

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{0 730}	Continued From page 19 the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure documentation of services that have been provided as identified in the care plan for one of two residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include:	{0 730}		

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{0 730}	Continued From page 20 R1 diagnoses include arterial fibrillation, CAD (coronary artery disease) and chronic kidney disease. R1's February 2023, Care Plans indicated R1 received the following services: -dressing and grooming a.m. and p.m.; and -weekly weights. R1's February 2023, Care Plan indicated the unlicensed personnel (ULP) documented the following services: -dressing and grooming a.m. and p.m. 25 out of 28 opportunities; and -weekly weights three out of four opportunities. On March 14, 2023, at 2:00 p.m. registered nurse consultant (RNC)-K stated R1's services were documented as indicated above. RNC-K stated they continue to work with staff on the importance of documentation. The licensee's Client Records policy dated May 9, 2019, indicated the client's record included the following: -documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; and -documentation that services have been provided as identified in the service plan. No further information was provided.	{0 730}		
{0 810} SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and	{0 810}		

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{0 810}	Continued From page 21 maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to maintain the facility's fire safety and evacuation plan with required elements. This had the potential to directly affect all residents, staff, and visitors.	{0 810}		

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{0 810}	Continued From page 22 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). A record review of available documentation and interview were conducted on March 14, 2023, at approximately 9:30 a.m. of documents provided by executive director (ED)-J on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. Findings include: Record review of the available documentation indicated that the licensee did not have specific employee actions to be taken in the event of a fire or similar emergency located within the plan. Record review of the available documentation indicated that the licensee did not have fire protection procedures necessary for residents located within the plan. Record review of the available documentation indicated that the fire safety and evacuation plan did not include 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. Record review of the available documentation indicated that employees did not receive training upon initial hire and twice per year thereafter on	{0 810}		

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{0 810}	Continued From page 23 the facility fire safety and evacuation plan. The fire safety and evacuation plan was not available at all times and in a location known by all staff within the facility for the use of staff and occupants for guidance during an emergency. Record review of the available documentation indicated that the licensee did not provided training once per year to residents who are capable of self-evacuation on the proper actions to be taken in the event of a fire regarding movement, evacuation, and relocation. Record review of the available documentation did not indicate that evacuation drills had been conducted twice per year per shift and least once every other month as required. All deficiencies were verified by ED-J during the interview at approximately 10:30 a.m.	{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	{01370}		

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SCANDIA CAPITAL PARTNERS LLC	102 NORTH 58TH AVENUE WEST DULUTH, MN 55807

(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
{01370}	Continued From page 24 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 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 evaluations included all the required training for one of three employees (unlicensed personnel (ULP-G)). 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	{01370}		

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{01370}	Continued From page 25 a limited number of staff are involved or the situation has occurred only occasionally in a limited number of locations). The findings include: ULP-G was hired on September 6, 2022, to provide direct care services under the licensee's assisted living with dementia care license. R1's February and March 2023, medication administration records (MAR) indicate ULP-G had administered R1' morning medications on several occasions. ULP-G's employee record lacked evidence ULP-G had received the following training and demonstrated competency: - 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;* - standby assistance techniques and how to perform them;* - medication (inhalers, eye drops and liquids), exercise, and treatment reminders; - 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; and - awareness of commonly used health technology equipment and assistive devices. (* denotes skills requiring competency testing) On March 14, 2023, at 4:00 p.m., registered nurse consultant (RNC)-K stated she was aware ULP-G's competencies were not complete.	{01370}		

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{01370}	Continued From page 26 The licensee's Staffing Competency policy dated August 1, 2021, indicated training and competency evaluations for all unlicensed personnel, include the following. Unlicensed personnel may not work for [facility name] until they have successfully passed the written competency test (at 80%) and demonstration competency evaluation. - maintenance of a clean and safe environment; - 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 iv. dressing and assisting with toileting; - training on the prevention of falls; - standby assistance techniques and how to perform them; - medication, exercise, and treatment reminders; - 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; - awareness of confidentiality and privacy; - understanding appropriate boundaries between staff and residents and the resident's family; and - awareness of commonly used health technology equipment and assistive devices. No further information was provided.	{01370}		
{01380} SS=D	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting	{01380}		

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{01380}	Continued From page 27 resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency evaluations included all the required training for one of three employees (unlicensed personnel (ULP)-G). 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 in a limited number of locations). The findings include: ULP-G was hired on September 6, 2022, to provide direct care services under the licensee's assisted living with dementia care license. R1's February and March 2023, medication	{01380}		

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{01380}	Continued From page 28	{01380}		

administration records (MAR) indicate ULP-G had administered R1' morning medications on several occasions.

ULP-G's employee record lacked evidence ULP-G had received the following training and demonstrated competency:
- basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel;
- reading and recording temperature, pulse, and respirations of the resident;*
- recognizing physical, emotional, cognitive, and developmental needs of the resident;
- safe transfer techniques and ambulation;*
- range of motioning and positioning;* and
- administering medications or treatments as required.*
(* denotes skills requiring competency testing)

On March 14, 2023, at 4:00 p.m., registered nurse consultant (RNC)-K stated she was aware ULP-G's competencies were not complete.

The licensee's Staffing Competency policy dated August 1, 2021, indicated training and competency evaluations for all unlicensed personnel include the following. Unlicensed personnel may not work for [facility name] until they have successfully passed
the written competency test (at 80%) and demonstration competency evaluation.
- basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel;
- reading and recording temperature, pulse, and respirations of the resident;
- recognizing physical, emotional, cognitive, and

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{01380}	Continued From page 29 developmental needs of the resident; - safe transfer techniques and ambulation; - range of motioning and positioning; and - administering medications or treatments as required. No further information was provided.	{01380}		
{01420} SS=D	144G.62 Subd. 2 Delegation of assisted living services (b) When the registered nurse or licensed health professional delegates tasks to unlicensed personnel, that person must ensure that prior to the delegation the unlicensed personnel is trained in the proper methods to perform the tasks or procedures for each resident and is able to demonstrate the ability to competently follow the procedures and perform the tasks. If the unlicensed personnel has not regularly performed the delegated assisted living task for a period of 24 consecutive months, the unlicensed personnel must demonstrate competency in the task to the registered nurse or appropriate licensed health professional. The registered nurse or licensed health professional must document instructions for the delegated tasks 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 registered nurse (RN) conducted training and competency evaluations for one of one unlicensed personnel (ULP)-G who performed weights. 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	{01420}		

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{01420}	Continued From page 30 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: ULP-G was hired on September 9, 2022, to provide direct care services under the licensee's assisted living with dementia care license. R1's Daily Monitoring Flowsheet indicated ULP-G performed R1's weight on February 6, 2023. ULP-G's employee record lacked evidence ULP-G had been trained by a RN and demonstrated they were competent to perform weights. On March 14, 2023, registered nurse consultant (RNC)-K confirmed ULP-G had not been trained by a RN and demonstrated ULP-G was competent to perform weights. The licensee's Delegation of Assisted Living Services policy dated August 1, 2021, indicated the Registered Nurse or licensed health professional is responsible for appropriately delegating tasks to staff who possess the knowledge and skills consistent with the complexity of the tasks in accordance with the appropriate Minnesota Practice Act. No further information was provided.	{01420}		
{01620} SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring	{01620}		

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{01620}	Continued From page 31 (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a registered nurse (RN) completed an assessment of one of one resident's skin (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or	{01620}		

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{01620}	Continued From page 32 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On March 14, 2023, at 8:15 a.m. registered nurse consultant (RNC)-K provided the evaluator the current resident roster. RNC stated R4 was receiving wound care by hospice. R4's record contained the following prescriber's orders: - Prescriber's order dated November 16, 2022, included cleanse left buttocks with wound cleanser, then apply zinc barrier cream BID (twice a day) and PRN (as needed) to coccyx. - Prescriber's order dated January 18, 2023, included left posterior wound care: cleanse area with wound cleanser, pat dry, apply Mepilex (foam dressing). Change every 2 days and PRN. - Prescriber's order dated January 24, 2023, included apply a thin layer of zinc barrier cream to buttocks and under abdominal folds BID and PRN. - Prescriber's order dated February 14, 2023, included wound care to left posterior arm, cleanse area with wound cleanser, pat dry, apply Mepilex. Change dressing every 7 days and PRN. Wound care to left buttock, cleanse with soap and water, pat dry, and apply Mepilex. Change every 7 days and PRN. R4's January 2023, treatment record indicated the following: - Cleanse R4's left buttock area with wound cleanser, the apply zinc barrier cream BID and PRN. Unlicensed personal (ULP) documented the treatment was completed twice a day on January 3, 2023, to January 31, 2023. - Left posterior wound care: cleanse area with	{01620}		

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{01620}	Continued From page 33 wound cleanser, pat dry, apply Mepilex (foam dressing). Change every 2 days and PRN. ULP documented the wound care was completed every 2 days from January 18, 2023, to January 31, 2023. -Apply moisture barrier, thin layer of zinc barrier cream to buttocks and under abdominal folds BID and PRN. ULP documented the moisture barrier was applied on January 24, 2023, to January 31, 2023. R4's February 2023, Daily Medication Record indicated: - Wound Care to left posterior arm, cleanse area with wound cleanser, pat dry, apply Mepilex and change every 7 days. ULP documented the treatment was performed on February 15, 2023. A notation on the Daily Medication Record indicated hospice discontinued the order on February 21, 2023. - Wound care to left buttocks cleanse area with soap and water, pat dry, apply Mepilex, and change every 7 days and PRN. ULP documented the treatment was performed on February 15, 17, 25, and 27, 2023. R4's March 2023, Daily Medication Record indicated: - Zinc barrier cream applied to buttock and abdominal folds twice a day. ULP documented the barrier cream was applied twice a day. ULP document the zinc barrier is applied twice a day. R4's RN Comprehensive Assessment dated February 14, 2023, indicated R1's skin was "pale". On March 14, 2023, at 2:19 p.m., ULP-H stated R4's buttock used to have blister that opened up, but the area is now healed. R4's abdominal folds	{01620}		

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{01620}	Continued From page 34 are red at times. R4's record lacked evidence a RN assessed the above identified changes in R4's skin condition. On March 14, 2023, at 2:00 p.m., RNC-K the only RN assessment in R4's record addressing R4's skin was completed on February 14, 2023. The licensee's Assessment- Comprehensive Services policy dated August 1, 2021, indicated ongoing client monitoring and reassessment must be conducted as needed based on changes in the needs of the client, but cannot exceed 90 days. No further information was provided.	{01620}		
{01650} SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an	{01650}		

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{01650}	Continued From page 35 emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the service plans included the required content for two of two residents (R1, R4). 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: R1 R1's service plan dated August 2, 2021, indicated services included medication administration, assistance with showers two (2) times a week, dressing daily, grooming a.m. and p.m., weekly laundry and housekeeping, and safety checks every two (2) hours. R4 R4's service plan dated February 9, 2022, indicated services included medication	{01650}		

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{01650}	Continued From page 36 administration, assistance with shower weekly, and weekly laundry and housekeeping. R1 and 4's service plans did not include the following information: - method of monitoring staff providing services. On March 14, 2023, at 2:00 p.m. registered nurse consultant (RNC)-K stated R1, R4 and all other resident's receiving service under the licensee's assisted living with dementia care license service plans did not include the method of monitoring staff providing services The licensee's Service Plans policy dated May 9, 2019, indicated the service plan included: -the frequency of sessions of supervision of staff and type of personnel who would supervise staff. No further information was provided. .	{01650}		
{01750} SS=G	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures;	{01750}		

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{01750}	Continued From page 37 (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure competence prior to delegating the nursing task of medication administration, for one of three unlicensed personnel (ULP-G) demonstrated competency for administering medications. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). This resulted in an immediate order on March 14, 2023. The findings include: ULP-G was hired on September 12, 2022, to provide direct care services under the licensee's assisted living with dementia care license. ULP-G's training record lacked evidence ULP-G had been trained and demonstrated competency in medication administration to include inhalers and liquid medications. R1's February 2023 medication administration	{01750}		

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{01750}	Continued From page 38	{01750}		

record indicated ULP-G administered the following medications:
-Flovent HFA AER (Treat Asthma and COPD (chronic obstructive pulmonary disease) 220 mcg (micrograms) inhale one puff every morning on February 3, 4, 5, 6, 13, 17, 18, 24 and 25, 2023.
-Polyeth Glye 3350 (laxative) mix 17 grams (one cap full) with at least eight (8) ounces of liquid and drink daily on February 3, 4, 5, 6, 13, 17, 18, 24 and 25, 2023.

R1's March 2023 MAR indicated ULP-G administered the following medications:
-Flovent HFA AER 220 mcg inhale one puff every morning on March 3, 4, 5, 6, 10, 11, 12, and 13, 2023.
-Polyeth Glye 3350 (laxative) mix 17 grams (one cap full) with at least eight (8) ounces of liquid and drink daily on March 3, 4, 5, 6, 10, 11, 12, and 13, 2023.

ULP-G's employee record indicated ULP-G was trained by the registered nurse (RN) and demonstrated competency for administering oral medications on February 10, 2023.

On March 14, 2023, at 2:00 p.m., RN consultant (RNC)-K stated ULP-G had administered the medications as indicated above. In addition, RNC-K stated ULP-G worked the night shift on March 13, 2023. RNC-K stated she did not come in to train ULP-G on medication administration and did not ask ULP-G to stay in the morning to complete the training.

The licensee's Medication Management policy dated September 16, 2022, indicated the registered nurse will ensure that med passers are trained in accordance with applicable state law.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30495	A. BUILDING: _____ B. WING _____	R 03/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCANDIA CAPITAL PARTNERS LLC	102 NORTH 58TH AVENUE WEST DULUTH, MN 55807

(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
{01750}	Continued From page 39 No further information was provided. TIME PERIOD FOR CORRECTION: Immediate Immediacy is removed as confirmed by evaluators' on-site observations and review by evaluation supervisor on March 15, 2023, however, noncompliance remains at a scope and level three, isolated (G).	{01750}		
{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 as prescribed for one of two residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	{01760}		

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{01760}	Continued From page 40 cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's diagnoses included atrial fibrillation, and chronic kidney disease. R1's service plan dated August 2, 2021, indicated services included medication administration. R1's prescriber's orders dated June 30, 2022, and March 2, 2023, included Metoprolol (treat atrial fibrillation) 10 mg (milligrams) one tablet every morning. R1's February and March 2023 medication administration records (MAR) indicated do not administer Metoprolol 10 mg if R1's pulse is below 60. R1's February 2023 MAR indicated R1's Metoprolol was administered on the following dates when R1's pulse was below 60: -February 2, 2023, pulse 58; -February 3, 2023, pulse 52; -February 4, 2023, pulse 52; -February 5, 2023, pulse 54; -February 6, 2023, pulse 52; -February 12, 2023, pulse 58; -February 17, 2023, pulse 54; -February 19, 2023, pulse 53; -February 21, 2023, pulse 57; -February 24, 2023, pulse 54; and -February 25, 2023, pulse 49. R1's March 2023, MAR indicated R1's Metoprolol	{01760}		

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{01760}	Continued From page 41 was administered on the following dated when R1's pulse was below 60: -March 2, 2023, pulse 58; -March 3, 2023, pulse 49; -March 4, 2023, pulse 52; -March 10, 2023, pulse 55; -March 12, 2023, pulse 52; and -March 13, 2023, pulse 49. On March 14, 2023, at 2:00 p.m., registered nurse consultant (RNC)-K confirmed R1's Metoprolol was administered as indicated above. RNC-K stated R1's Metoprolol should have been held when R1's pulse was below 60. RNC stated she would contact R1's prescriber regarding R1's Metoprolol order. No further information was provided.	{01760}		
{01790} SS=D	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may	{01790}		

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{01790}	Continued From page 42 delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the	{01790}		

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{01790}	Continued From page 43 doses of each returned medication. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure one of three employees (unlicensed personnel (ULP)-G), were trained, and demonstrated competency to prepare and give medications for residents having unplanned time away. This had the potential to affect all six (6) 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 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 in a limited number of locations). The findings include: ULP-G was hired on September 8, 2022, to provide direct care services under the licensee's assisted living with dementia care license. R1's February and March 2023, medication administration records (MAR) indicate ULP-G had administered R1' morning medications on several occasions. ULP-G's employee records lacked evidence ULP-G had been trained and demonstrated competency to prepare and provide medications to residents for unplanned times away from home.	{01790}		

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{01790}	Continued From page 44 On March 14, 2023, at 4:00 p.m., registered nurse consultant (RNC)-K stated she was aware ULP-G's competencies was not complete. The licensee's Protocol for Medications Away from Home (undated) indicated for unplanned time away (<24-hour business day notice) ULP can set up meds. The protocol did not address the training and competency of the ULP pertaining to the setting up of resident medications for unplanned time away from home. No further information was provided.	{01790}		
{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 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. This deficient practice had the ability to affect all staff, residents, and visitors.	{02040}		

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{02040}	Continued From page 45 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). Findings include: A record review of available documentation and interview were conducted March 14, 2023, at approximately 10:00 a.m. with executive director (ED)-J on the hazard vulnerability assessment for the physical environment of the facility. Record review of the available documentation indicated that the licensee had not performed a hazard vulnerability assessment with mitigation factors on and around the property. This deficient condition was verified by ED-J during the interview at approximately 10:30 a.m.	{02040}		
{02170} SS=F	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following: (1) past and current interests; (2) current abilities and skills; (3) emotional and social needs and patterns; (4) physical abilities and limitations; (5) adaptations necessary for the resident to participate; and (6) identification of activities for behavioral	{02170}		

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{02170}	Continued From page 46 interventions. (c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs. (d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to: (1) occupation or chore related tasks; (2) scheduled and planned events such as entertainment or outings; (3) spontaneous activities for enjoyment or those that may help defuse a behavior; (4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music; (5) spiritual, creative, and intellectual activities; (6) sensory stimulation activities; (7) physical activities that enhance or maintain a resident's ability to ambulate or move; and (8) outdoor activities. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop an individualized activity plan with required content based on the evaluation, for two of two residents (R1, R4) who received services under an assisted living with dementia care license. 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	{02170}		

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{02170}	Continued From page 47 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: R1 R1's diagnoses included arterial fibrillation, CAD (coronary artery disease) and chronic kidney disease. R1's Dementia Activity Assessment tool, dated February 10, 2023, indicated R1 was evaluated for the following activities: - past and current interests - current abilities and skills - emotional and social needs and patterns - physical abilities and limitations - adaptations necessary for the resident to participate; and - identification of activities for behavioral interventions R1's record lacked the development of an individualized activity plan. R4 R4's diagnoses included hypothyroidism, and hypertension. R4's Dementia Activity Assessment tool, dated February 14, 2023, indicated R4 was evaluated for the following activities: - past and current interests - current abilities and skills - emotional and social needs and patterns - physical abilities and limitations - adaptations necessary for the resident to participate; and - identification of activities for behavioral	{02170}		

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{02170}	Continued From page 48 interventions R4's record lacked the development of an individualized activity plan. On March 14, 2023, at 2:00 p.m. registered nurse consultant (RNC)-K stated all residents had been evaluated, but an individualized activity plan had not been developed for R1, R4, and all residents receiving services under the licensee's assisted living with dementia care license. No further information was provided.	{02170}		

Electronically Delivered

February 14, 2023

Licensee
Scandia Capital Partners LLC
102 North 58th Avenue West
Duluth, MN 55807

RE: Project Number(s) SL30495015

Dear Licensee:

On February 2, 2023, February 4, 2023, and February 5, 2023, the Minnesota Department of Health completed a monitoring visit of your facility to assess the progress of Scandia Capital Partners LLC to correct the violations cited during the evaluation on December 7, 2022, and during the monitoring visit completed December 30, 2022.

At this time, the monitoring visit was focused on tag order identification 0110, 0340, 0495, 1290, and 2070.

This monitoring visit found your facility is not correcting all of the state licensing orders issued pursuant to the December 7, 2022, evaluation and the December 30, 2022, monitoring visit.

As a result of the monitoring visit and in accordance with Minn. Stat. § 144G.31 Subd. 4 (a), the reissued tags subject to immediate penalty assessment are as follows:

0340-Correction Orders-144g.30 Subd. 5 - $3,000.00

0495-Minimum Requirements-144g.41 Subd. 1 (14) - $3,000.00

The details of the violations noted at the time of this follow-up evaluation completed on February 5, 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, **the total amount you are assessed is $6,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), 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 Jessica Chenze, at 218-332-5175.

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,

Jessica Chenze, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: jessica.chenze@state.mn.us
Telephone: | Fax: 218-332-5196

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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SCANDIA CAPITAL PARTNERS LLC	102 NORTH 58TH AVENUE WEST DULUTH, MN 55807

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{0 000}	Initial Comments *****ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been 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: Project SL30495015-2 On February 2, 2023, February 4, 2023, and February 5, 2023, the Minnesota Department of Health conducted monitoring visit with the above provider to follow-up on orders issued pursuant to a survey completed on December 7, 2022. At this time, the monitoring visit was focused on tag order identification 0110, 0340, 0495, 1290, and 2070. As a result of the monitoring visit, the following orders were reissued. Immediate correction orders were identified on February 2, 2023, and reissued for SL30495015-2, tag identification 0495. On February 6, 2023, the immediacy of correction order 0495 was removed, however non-compliance remained at a scope and level of I.	{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 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.	

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{0 250}	Continued From page 1	{0 250}		
{0 250} SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter;	{0 250}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30495	A. BUILDING: _____ B. WING _____	R 02/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCANDIA CAPITAL PARTNERS LLC	102 NORTH 58TH AVENUE WEST DULUTH, MN 55807

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{0 250}	Continued From page 2 (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by:	{0 250}		
{0 340} SS=I	144G.30 Subd. 5 Correction orders (a) A correction order may be issued whenever the commissioner finds upon survey or during a complaint investigation that a facility, a managerial official, or an employee of the facility is not in compliance with this chapter. The correction order shall cite the specific statute and document areas of noncompliance and the time allowed for correction. (b) The commissioner shall mail or e-mail copies of any correction order to the facility within 30 calendar days after the survey exit date. A copy of each correction order and copies of any documentation supplied to the commissioner shall be kept on file by the facility and public documents shall be made available for viewing by any person upon request. Copies may be kept electronically. (c) By the correction order date, the facility must	{0 340}		

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{0 340}	Continued From page 3 document in the facility's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the facility's action to respond to the correction order in future surveys, upon a complaint investigation, and as otherwise needed. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to have sufficient documentation with actions taken to comply with immediate order, tag identification 0495 during a survey completed on December 7, 2022. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On December 7, 2022, the Minnesota Department of Health completed a survey resulting in 36 correction order and immediate orders 0110, 0495, 1290, 1750 and 2070. On December 30, 2022, the Minnesota Department of Health completed a monitoring communication with the licensee. The licensee failed to provide sufficient documentation with actions taken to comply with the immediate order tag identifications 0110 and 0495, as well as requirements outlined in the letter of Notice of	{0 340}		

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{0 340}	Continued From page 4 Conditional License. During a monitoring visit on February 2, 2023, the evaluator conducted observations, reviewed resident and employee records, interviewed owner/agent (O/A)-E, registered nurse (RN)-K, unlicensed personnel (ULP)-B, community coordinator (CC)-A, and communicated via email with licensed assisted living director (LALD)-L. The licensee lacked evidence to indicate 0340 and 0495 issued on December 7, 2022, were corrected. No further information was provided.	{0 340}		
{0 430} SS=C	144G.40 Subd. 2 Uniform checklist disclosure of services (a) All assisted living facilities must provide to prospective residents: (1) a disclosure of the categories of assisted living licenses available and the category of license held by the facility; (2) a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and (3) an oral explanation of the services offered under the contract. (b) The requirements of paragraph (a) must be completed prior to the execution of the assisted living contract. (c) The commissioner must, in consultation with all interested stakeholders, design the uniform checklist disclosure form for use as provided under paragraph (a).	{0 430}		

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{0 430}	Continued From page 5 This MN Requirement is not met as evidenced by:	{0 430}		
{0 450} SS=C	144G.41 Subdivision 1 Minimum requirements All assisted living facilities shall: (1) distribute to residents the assisted living bill of rights; (2) provide services in a manner that complies with the Nurse Practice Act in sections 148.171 to 148.285; (3) utilize a person-centered planning and service delivery process; (4) have and maintain a system for delegation of health care activities to unlicensed personnel by a registered nurse, including supervision and evaluation of the delegated activities as required by the Nurse Practice Act in sections 148.171 to 148.285; This MN Requirement is not met as evidenced by:	{0 450}		
{0 470} SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies	{0 470}		

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{0 470}	Continued From page 6 and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by:	{0 470}		
{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	{0 480}		

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{0 480}	Continued From page 7 This MN Requirement is not met as evidenced by:	{0 480}		
{0 495} SS=I	144G.41 Subd. 1 (14) Minimum Requirements (14) provide staff access to an on-call registered nurse 24 hours per day, seven days per week. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure that a registered nurse (RN) was available on-call 24 hours a day, seven days per week. This had the potential to affect all seven (7) residents and staff of the facility. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). This resulted in a reissue immediate correction order on February 2, 2023. The findings include: On February 2, 2023, at 10:03 a.m., the evaluator called RN-K's phone. RN-K did not answer the phone. The evaluator left a message for RN-J to	{0 495}		

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{0 495}	Continued From page 8 return the call. On February 2, 2023, at 10:56 a.m., owner/agent (O/A)-E called the evaluator. O/A-E stated RN-K was working part time because she has another job in the morning and is unavailable. O/A-E stated RN-K was working at all three facilities in the Duluth location. O/A-E stated they had also hired another RN who would be starting in a few weeks because she needs to give notice to her current employer. O/A-E stated this RN would be working full time for the three sites in Duluth and would be starting no later than February 27, 2023. On February 2, 2023, at 11:38 a.m., RN-K called the evaluator. RN-K stated she was not on call 24/7 for the facilities. RN-K stated she was on site about a half hour on February 1, 2023. Because there was no equipment (computer) for her use, RN-K left. RN-K stated on February 1, 2023, RN-K emailed the licensed assisted living director (LALD)-L stating that she was resigning as of today. RN-K stated she never received any orientation and had been told that she was only there to update care plans. RN-K stated O/A-E called her this morning and asked her why she was resigning. RN-J stated she told O/A-E that she valued her license, and she was not going to put her license on the line. On February 2, 2023, at 12:00 p.m., community coordinator (CC)-A stated RN-K was onsite yesterday. A letter on the bulletin board in the office indicated RN-K was on call 24/7 and RN-K's phone number. No further information was provided. On February 6, 2023, the immedediacy was removed as confirmed by supervisor evaluation,	{0 495}		

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{0 495}	Continued From page 9 however, noncompliance remains at a scope and level of three, widespread (I).	{0 495}		
{0 510} SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by:	{0 510}		
{0 580} SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal.	{0 580}		

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{0 580}	Continued From page 10 This MN Requirement is not met as evidenced by:	{0 580}		
{0 630} SS=E	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by:	{0 630}		
{0 650} SS=E	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations;	{0 650}		

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{0 650}	Continued From page 11 (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. (b) Each employee record must be retained for at least three years after a paid employee, volunteer, or contractor ceases to be employed by, provide services at, or be under contract with the facility. If a facility ceases operation, employee records must be maintained for three years after facility operations cease. This MN Requirement is not met as evidenced by:	{0 650}		
{0 660} SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide	{0 660}		

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{0 660}	Continued From page 12 technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by:	{0 660}		
{0 680} SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (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.	{0 680}		

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{0 680}	Continued From page 13 This MN Requirement is not met as evidenced by:	{0 680}		
{0 730} SS=E	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care	{0 730}		

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{0 730}	Continued From page 14 professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by:	{0 730}		
{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; (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:	{0 790}		

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{0 800}	Continued From page 15	{0 800}		
{0 800} SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by:	{0 800}		
{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	{0 810}		

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{0 810}	Continued From page 16 their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by:	{0 810}		
{0 900} SS=E	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has	{0 900}		

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{0 900}	Continued From page 17 been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by:	{0 900}		
{01370} SS=F	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;	{01370}		

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{01370}	Continued From page 18 (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 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:	{01370}		
{01380} SS=F	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to	{01380}		

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{01380}	Continued From page 19 appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by:	{01380}		
{01420} SS=D	144G.62 Subd. 2 Delegation of assisted living services (b) When the registered nurse or licensed health professional delegates tasks to unlicensed personnel, that person must ensure that prior to the delegation the unlicensed personnel is trained in the proper methods to perform the tasks or procedures for each resident and is able to demonstrate the ability to competently follow the procedures and perform the tasks. If an unlicensed personnel has not regularly performed the delegated assisted living task for a period of 24 consecutive months, the unlicensed personnel must demonstrate competency in the task to the registered nurse or appropriate licensed health professional. The registered nurse or licensed health professional must document instructions for the delegated tasks in the resident's record. This MN Requirement is not met as evidenced by:	{01420}		

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{01440}	Continued From page 20	{01440}		
{01440} SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by:	{01440}		
{01620} SS=E	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the	{01620}		

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{01620}	Continued From page 21 resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by:	{01620}		
{01650} SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes:	{01650}		

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{01650}	Continued From page 22 (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by:	{01650}		
{01710} SS=E	144G.71 Subd. 3 Individualized medication monitoring and reas The assisted living facility must monitor and reassess the resident's medication management services as needed under subdivision 2 when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually. This MN Requirement is not met as evidenced by:	{01710}		
{01750} SS=H	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated	{01750}		

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{01750}	Continued From page 23 to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by:	{01750}		
{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:	{01760}		

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{01790}	Continued From page 24	{01790}		
{01790} SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in	{01790}		

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{01790}	Continued From page 25 the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by:	{01790}		
{01910} SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service	{01910}		

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{01910}	Continued From page 26 contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by:	{01910}		
{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 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:	{02040}		
{02110} SS=F	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the	{02110}		

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{02110}	Continued From page 27 assisted living facility with dementia care licensee must develop and implement policies and procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in. This MN Requirement is not met as evidenced by:	{02110}		

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{02170}	Continued From page 28	{02170}		
{02170} SS=E	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following: (1) past and current interests; (2) current abilities and skills; (3) emotional and social needs and patterns; (4) physical abilities and limitations; (5) adaptations necessary for the resident to participate; and (6) identification of activities for behavioral interventions. (c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs. (d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to: (1) occupation or chore related tasks; (2) scheduled and planned events such as entertainment or outings; (3) spontaneous activities for enjoyment or those that may help defuse a behavior; (4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music; (5) spiritual, creative, and intellectual activities; (6) sensory stimulation activities; (7) physical activities that enhance or maintain a resident's ability to ambulate or move; and (8) outdoor activities.	{02170}		

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{02170}	Continued From page 29 This MN Requirement is not met as evidenced by:	{02170}		
{02410} SS=E	144G.91 Subd. 13 Personal and treatment privacy (a) Residents have the right to consideration of their privacy, individuality, and cultural identity as related to their social, religious, and psychological well-being. Staff must respect the privacy of a resident's space by knocking on the door and seeking consent before entering, except in an emergency or where clearly inadvisable or unless otherwise documented in the resident's service plan. (b) Residents have the right to have and use a lockable door to the resident's unit. The facility shall provide locks on the resident's unit. Only a staff member with a specific need to enter the unit shall have keys. This right may be restricted in certain circumstances if necessary for a resident's health and safety and documented in the resident's service plan. (c) Residents have the right to respect and privacy regarding the resident's service plan. Case discussion, consultation, examination, and treatment are confidential and must be conducted discreetly. Privacy must be respected during toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance. This MN Requirement is not met as evidenced by:	{02410}		

Electronically Delivered

December 30, 2022

Licensee
Scandia Capital Partners, LLC
102 North 58th Avenue West
Duluth, MN 55807

RE: Project Number(s) SL30495015

Dear Licensee:

On December 30, 2022, 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 7, 2022. This follow-up evaluation determined your facility had not corrected all of the state licensing orders issued pursuant to the December 7, 2022 evaluation.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state licensing orders issued pursuant to the last evaluation completed on December 7, 2022, found not corrected at the time of the December 30, 2022, follow-up evaluation and/or subject to penalty assessment are as follows:

0340-Correction Orders-144g.30 Subd. 5 = $3,000

The details of the violations noted at the time of this follow-up evaluation completed on December 31, 2022 (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, **the total amount you are assessed is $3,000**. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

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 have one opportunity to challenge the correction order issued, including the level and scope, and any fine assessed through the correction order reconsideration process. This written request must be received by the Department of Health within 15 calendar days of the correction order receipt date. Please send your written request via email to the following:

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

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. 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 Jessie Chenze at 218-332-5175.

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,

Jessie Chenze, RN, BSN
Supervisor 1 | State Evaluations Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Office: 218-332-5175 | Fax: 218-332-5196

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30495	A. BUILDING: _____ B. WING _____	R 12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCANDIA CAPITAL PARTNERS LLC	102 NORTH 58TH AVENUE WEST DULUTH, MN 55807

(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 Initial comments *****ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been 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: Project SL30495015-1 On December 23, 2022, through December 30, 2022, the Minnesota Department of Health conducted monitoring correspondence with the above provider to follow-up on orders issued pursuant to a survey completed on December 7, 2022. At this time, the monitoring correspondence was focused on tag order identification 0340 and requirements of conditional license. As a result of the communicaitons, the following orders were reissued.	{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 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.	
{0 110} SS=I	144G.10 Subdivision 1a Assisted living director license required	{0 110}		

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{0 110}	Continued From page 1 Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports. This MN Requirement is not met as evidenced by:	{0 110}		
{0 250} SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents;	{0 250}		

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{0 250}	Continued From page 2 (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by:	{0 250}		
{0 340} SS=I	144G.30 Subd. 5 Correction orders (a) A correction order may be issued whenever the commissioner finds upon survey or during a complaint investigation that a facility, a managerial official, or an employee of the facility is not in compliance with this chapter. The correction order shall cite the specific statute and document areas of noncompliance and the time allowed for correction.	{0 340}		

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{0 340}	Continued From page 3 (b) The commissioner shall mail or e-mail copies of any correction order to the facility within 30 calendar days after the survey exit date. A copy of each correction order and copies of any documentation supplied to the commissioner shall be kept on file by the facility and public documents shall be made available for viewing by any person upon request. Copies may be kept electronically. (c) By the correction order date, the facility must document in the facility's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the facility's action to respond to the correction order in future surveys, upon a complaint investigation, and as otherwise needed. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide sufficient documentation with actions taken to comply with the immediate order tag identifications 0110 and 0495, as well as requirements outlined in the letter of Notice of Conditional License, during monitoring communication completed on December 30, 2022. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include:	{0 340}		

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{0 340}	Continued From page 4 On December 20, 2022, Minnesota Department of Health (MDH) emailed a Notice of Conditional License letter to the licensee, outlining requirements the licensee must take, including: -Fill vacant positions: Scandia Capital Partners LLC must fill the vacant Assisted Living Director and Clinical Nurse Supervisor positions with appropriately licensed individuals by December 27, 2022. -Consultant: Scandia Capital Partners LLC will contract with an RN (registered nurse) to provide consultation concerning all resident(s) to whom Scandia Capital Partners LLC provides licensed assisted living services under the conditional license. On December 23, 2022, at 9:00 a.m., MDH State Evaluations supervisors and management members held an informal conference with owner/agent (O/A)-E, regional director/licensed practical nurse (RD/LPN)-D, and assistant regional director (ARD)-H. MDH outlined expectations and concerns during the informal conference. O/A-E, RD/LPN-D, and ARD-J verbalized understanding of expectations, including filling of vacant positions. RD/LPN-D stated she was a licensed assisted living director (LALD) and would begin to work on establishing herself as the facility's LALD that day. O/A-E and RD/LPN-D confirmed an RN had been hired, although could not begin employment until January 3, 2023. On December 27, 2022, as of 4:00 p.m., the Board of Executives for Long-Term Services and Supports (BELTSS) website did not indicate RD/LPN-D to be the director of record for the licensee.	{0 340}		

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{0 340}	Continued From page 5 On December 28, 2022, at 11:02 a.m., evaluation supervisor attempted to call RD/LPN-D, however, the voice mailbox was full. On December 28, 2022, at 11:24 a.m., evaluation supervisor emailed RD/LPN-D and O/A-E to inquire as to the status of filling the vacant positions and hiring an RN consultant. At 11:30 a.m., O/A-E responded RD/LPN-D would be the LALD, an RN was hired, and an RN consultant had been retained. On December 28, 2022, at 12:55 p.m., evaluation supervisor inquired via email if RD/LPN-D had established herself as director of record with BELTSS, what the starting date was for the RN, and the plan for the required interim coverage needed. On December 28, 2022, at 1:06 p.m., evaluation supervisor emailed RN consultant to inquire about receiving a resume. On December 28, 2022, at 1:45 p.m., RD/LPN-D indicated she had not yet reached out to BELTSS to establish herself as the facility LALD. RD/LPN-D additionally indicated the RN would not be starting employment until January 3, 2023, and RD/LPN-D would be the backup plan for nursing coverage until then. On December 28, 2022, at 1:53 p.m., evaluation supervisor received an email from the RN consultant agency, indicating an RN consultant had not yet been assigned, as the agency was waiting to learn the expectations of on-site time. Evaluation supervisor responded that MDH's expectations would include periodic on-site visits. On December 30, 2022, at 8:15 a.m., evaluation	{0 340}		

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{0 340}	Continued From page 6 supervisor emailed RD/LPN-D and O/A-E inquiring if they completed the requirements with BELTSS, and for the name of the specific RN consultant the licensee had retained. At 8:45 a.m., RD/LPN-D responded via email she would work with BELTSS on Monday (January 2, 2023) and requested O/A-E to provide information on the RN consultant. No further information was provided.	{0 340}		
{0 430} SS=C	144G.40 Subd. 2 Uniform checklist disclosure of services (a) All assisted living facilities must provide to prospective residents: (1) a disclosure of the categories of assisted living licenses available and the category of license held by the facility; (2) a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and (3) an oral explanation of the services offered under the contract. (b) The requirements of paragraph (a) must be completed prior to the execution of the assisted living contract. (c) The commissioner must, in consultation with all interested stakeholders, design the uniform checklist disclosure form for use as provided under paragraph (a). This MN Requirement is not met as evidenced by:	{0 430}		

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{0 450}	Continued From page 7	{0 450}		
{0 450} SS=C	144G.41 Subdivision 1 Minimum requirements All assisted living facilities shall: (1) distribute to residents the assisted living bill of rights; (2) provide services in a manner that complies with the Nurse Practice Act in sections 148.171 to 148.285; (3) utilize a person-centered planning and service delivery process; (4) have and maintain a system for delegation of health care activities to unlicensed personnel by a registered nurse, including supervision and evaluation of the delegated activities as required by the Nurse Practice Act in sections 148.171 to 148.285; This MN Requirement is not met as evidenced by:	{0 450}		
{0 470} SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week,	{0 470}		

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{0 470}	Continued From page 8 who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by:	{0 470}		
{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	{0 480}		

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{0 480}	Continued From page 9 by:	{0 480}		
{0 495} SS=I	144G.41 Subd. 1 (14) Minimum Requirements (14) provide staff access to an on-call registered nurse 24 hours per day, seven days per week. This MN Requirement is not met as evidenced by:	{0 495}		
{0 510} SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by:	{0 510}		
{0 580} SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality	{0 580}		

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{0 580}	Continued From page 10 management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by:	{0 580}		
{0 630} SS=E	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by:	{0 630}		
{0 650} SS=E	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of	{0 650}		

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{0 650}	Continued From page 11 each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. (b) Each employee record must be retained for at least three years after a paid employee, volunteer, or contractor ceases to be employed by, provide services at, or be under contract with the facility. If a facility ceases operation, employee records must be maintained for three years after facility operations cease. This MN Requirement is not met as evidenced by:	{0 650}		
{0 660} SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a	{0 660}		

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{0 660}	Continued From page 12 comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by:	{0 660}		
{0 680} SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (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.	{0 680}		

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{0 680}	Continued From page 13 (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by:	{0 680}		
{0 730} SS=E	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans;	{0 730}		

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{0 730}	Continued From page 14 (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by:	{0 730}		
{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; (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,	{0 790}		

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{0 790}	Continued From page 15 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:	{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:	{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	{0 810}		

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{0 810}	Continued From page 16 emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by:	{0 810}		
{0 900} SS=E	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and	{0 900}		

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{0 900}	Continued From page 17 (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by:	{0 900}		
{01290} SS=G	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring	{01290}		

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{01290}	Continued From page 18 self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by:	{01290}		
{01370} SS=F	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 perform them; (8) medication, exercise, and treatment	{01370}		

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{01370}	Continued From page 19 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:	{01370}		
{01380} SS=F	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation;	{01380}		

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{01380}	Continued From page 20 (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by:	{01380}		
{01420} SS=D	144G.62 Subd. 2 Delegation of assisted living services (b) When the registered nurse or licensed health professional delegates tasks to unlicensed personnel, that person must ensure that prior to the delegation the unlicensed personnel is trained in the proper methods to perform the tasks or procedures for each resident and is able to demonstrate the ability to competently follow the procedures and perform the tasks. If an unlicensed personnel has not regularly performed the delegated assisted living task for a period of 24 consecutive months, the unlicensed personnel must demonstrate competency in the task to the registered nurse or appropriate licensed health professional. The registered nurse or licensed health professional must document instructions for the delegated tasks in the resident's record. This MN Requirement is not met as evidenced by:	{01420}		
{01440} SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living	{01440}		

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{01440}	Continued From page 21 facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by:	{01440}		
{01620} SS=E	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be	{01620}		

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{01620}	Continued From page 22 completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by:	{01620}		
{01650} SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse	{01650}		

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{01650}	Continued From page 23 change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by:	{01650}		
{01710} SS=E	144G.71 Subd. 3 Individualized medication monitoring and reas The assisted living facility must monitor and reassess the resident's medication management services as needed under subdivision 2 when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually. This MN Requirement is not met as evidenced by:	{01710}		
{01750} SS=H	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for	{01750}		

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{01750}	Continued From page 24 each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by:	{01750}		
{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:	{01760}		
{01790} SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to	{01790}		

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{01790}	Continued From page 25	{01790}		

exceed seven calendar days;
(3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and
(4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled.
(b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if:
(1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and
(2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address:
(i) the type of container or containers to be used for the medications appropriate to the provider's medication system;
(ii) how the container or containers must be labeled;
(iii) written information about the medications to be provided;
(iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information;
(v) how the registered nurse shall be notified that

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{01790}	Continued From page 26 medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by:	{01790}		
{01910} SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given,	{01910}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30495	A. BUILDING: _____ B. WING _____	R 12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCANDIA CAPITAL PARTNERS LLC	102 NORTH 58TH AVENUE WEST DULUTH, MN 55807

(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
{01910}	Continued From page 27 date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by:	{01910}		
{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 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:	{02040}		
{02070} SS=I	144G.81 Subd. 4 Awake staff requirement An assisted living facility with dementia care providing services in a secured dementia care unit must have an awake person who is physically present in the secured dementia care unit 24 hours per day, seven days per week, who is responsible for responding to the requests of residents for assistance with health and safety needs, and who meets the requirements of section 144G.41, subdivision 1, clause (12).	{02070}		

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{02070}	Continued From page 28 This MN Requirement is not met as evidenced by:	{02070}		
{02110} SS=F	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided	{02110}		

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{02110}	Continued From page 29 to residents and the residents' legal and designated representatives at the time of move-in. This MN Requirement is not met as evidenced by:	{02110}		
{02170} SS=E	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following: (1) past and current interests; (2) current abilities and skills; (3) emotional and social needs and patterns; (4) physical abilities and limitations; (5) adaptations necessary for the resident to participate; and (6) identification of activities for behavioral interventions. (c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs. (d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to: (1) occupation or chore related tasks; (2) scheduled and planned events such as entertainment or outings; (3) spontaneous activities for enjoyment or those that may help defuse a behavior; (4) one-to-one activities that encourage positive	{02170}		

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{02170}	Continued From page 30 relationships between residents and staff such as telling a life story, reminiscing, or playing music; (5) spiritual, creative, and intellectual activities; (6) sensory stimulation activities; (7) physical activities that enhance or maintain a resident's ability to ambulate or move; and (8) outdoor activities. This MN Requirement is not met as evidenced by:	{02170}		
{02410} SS=E	144G.91 Subd. 13 Personal and treatment privacy (a) Residents have the right to consideration of their privacy, individuality, and cultural identity as related to their social, religious, and psychological well-being. Staff must respect the privacy of a resident's space by knocking on the door and seeking consent before entering, except in an emergency or where clearly inadvisable or unless otherwise documented in the resident's service plan. (b) Residents have the right to have and use a lockable door to the resident's unit. The facility shall provide locks on the resident's unit. Only a staff member with a specific need to enter the unit shall have keys. This right may be restricted in certain circumstances if necessary for a resident's health and safety and documented in the resident's service plan. (c) Residents have the right to respect and privacy regarding the resident's service plan. Case discussion, consultation, examination, and treatment are confidential and must be conducted discreetly. Privacy must be respected during toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or	{02410}		

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{02410}	Continued From page 31 assistance. This MN Requirement is not met as evidenced by:	{02410}		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF CONDITIONAL LICENSE

Electronically Delivered

December 20, 2022

Administrator
Scandia Capital Partners LLC
102 North 58th Avenue West
Duluth, MN 55807

RE: Conditional License Number 408476
Health Facility Identification Number (HFID) 30495
Project Number(s) SL30495015

Dear Administrator:

The Minnesota Department of Health (MDH) completed a licensing evaluation on November 23, 2022, for the purpose of assessing compliance with state licensing statutes. During the on-site evaluation, five (5) harm level immediate orders were identified. The licensees failure to document actions taken to comply resulted in the orders remaining immediate. Based on the licensing evaluation results you were found not to be in substantial compliance with the laws pursuant to Minnesota Statutes, Chapter 144G.

As a result, MDH is issuing a 90-day conditional license due to expire on **March 20, 2023**.

INFORMAL CONFERENCE

In accordance with Minn. Stat. § 144A.475, Subd. 8 OR Minn. Stat. § 144G.20, Subd. 20, the Commissioner of Health is authorized to hold a conference to exchange information, clarify issues, or resolve issues.

The Department of Health staff would like to schedule an informal conference with Scandia Capital Partners LLC. Please contact Jessica Chenze at 218-332-5175 on or before Thursday, December 22, 2022, to schedule the informal conference.

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 . . ."

IMPOSITION OF FINES
In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and imposed immediately with no opportunity to correct the violation first as follows:

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

In accordance with Minn. Stat. § 144G.20, Subd. 4(a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572. Subds. 2, 9, 17. The Department of Health also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4(a)(5)(b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

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

St - 0 - 0110 - 144g.10 Subdivision 1a - Assisted Living Director License Required - $3,000.00
St - 0 - 0340 - 144g.30 Subd. 5 - Correction Orders - $3,000.00
St - 0 - 0495 - 144g.41 Subd. 1 (14) - Minimum Requirements - $3,000.00
St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00
St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required - $3,000.00
St - 0 - 1750 - 144g.71 Subd. 7 - Delegation Of Medication Administration - $3,000.00
St - 0 - 2070 - 144g.81 Subd. 4 - Awake Staff Requirement - $3,000.00

The total amount you are assessed is $18,500.00. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

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:

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

CONDITIONAL LICENSE ISSUED:
MDH will issue Scandia Capital Partners LLC a conditional assisted living facility license for 90 calendar days from the date of this notice. At an unannounced point in time, within the 90 calendar days, MDH will conduct a follow-up evaluation, as defined in Minn. Stat. § 144G.30, Subd. 6. Based on the results of the follow-up evaluation, MDH will determine if Scandia Capital Partners LLC is in substantial compliance.

The following conditions apply on the conditional assisted living facility license:

a. **No new substantiated maltreatment allegations:** If any new investigations begin in the conditional license period, and the allegations are substantiated, MDH may pursue additional enforcement actions up to and including immediate temporary suspension and revocation of the license.

b. **Fill vacant positions:** Scandia Capital Partners LLC must fill the vacant Assisted Living Director and Clinical Nurse Supervisor positions with appropriately licensed individuals by December 27, 2022.

c. **No new admissions:** Scandia Capital Partners LLC will not admit any new residents under its conditional assisted living facility license until the MDH removes the "no new admissions" condition. Scandia Capital Partners LLC must provide the Department:

    i. A list of the names and birthdates of any individuals Scandia Capital Partners LLC is currently in the process of admitting. These individuals will be able to continue the admittance process.

    ii. A list of all current residents by location including:
        1. Name and birthdate of each resident
        2. Physical location of each resident
        3. Current payment source for services
        4. If Elderly Waiver, the name and contact information of the care coordinator/case manager
        5. If the resident is not able to make informed decisions, the name of their representative and how to contact the representative

d. **Consultant:** Scandia Capital Partners LLC will contract with an RN to provide consultation concerning all resident(s) to whom Scandia Capital Partners LLC provides licensed assisted living services under the conditional license. <u>The consultant must have access to all resident(s) receiving services from Scandia Capital Partners LLC. The consultant will conduct initial and ongoing evaluations of the provider. Direct resident observation may be required based on the consultant's judgement or at the discretion of MDH</u>. The RN must not have any affiliation with Scandia Capital Partners LLC and MDH must

review the RN's credentials and approve the selection. Scandia Capital Partners LLC is responsible for the expense of the contract with the RN. The main purpose of the consultant is to provide guidance to Scandia Capital Partners LLC in an effort to help Scandia Capital Partners LLC align their practices with the requirements of Minn. Stat. §§ 144G.01 – 144G.9999 and to provide oral and written reports to MDH noting progress toward substantial compliance and/or concerns about observations. Scandia Capital Partners LLC will develop and implement policies, procedures, and processes specific to the offered services in accordance with the guidance provided by the consultant to ensure ongoing monitoring and substantial compliance with statutory requirements.

e. Reports: The RN consultant will provide MDH with regular reports at intervals specified by MDH. Reports will begin on a weekly basis until MDH notifies Scandia Capital Partners LLC and the RN consultant about a change. Each report will be electronically submitted to Jessica Chenze, Evaluator Supervisor, State Evaluation Team, Health Regulation Division, at jessica.chenze@state.mn.us. Jessica Chenze can be reached at 218-332-5175 (office) with questions about reports. The content of the reports will include information such as:

i. Progress towards correction of licensing orders;
ii. Observations of staff delivering assisted living services and the level of competency observed;
iii. Conversations with residents and family members about satisfaction with assisted living services;
iv. Conversations with staff about their level of knowledge about the tasks they perform, the people they serve and the health professionals who delegate to them;
v. Overall impressions about the quality of the assisted living services delivered;
vi. Overall impressions about the dignity with which the residents and their family members are treated;
vii. Concerns; and
viii. Any other information requested by the Department or considered important by the RN consultant(s).

f. Monitoring visits: MDH may make unannounced monitoring visits to assess the progress of Scandia Capital Partners LLC to correct the violations cited during the evaluation as well as to determine the overall practice of Scandia Capital Partners LLC in meeting the needs of the people it serves. In addition, the Office of Ombudsman for Long-Term Care (OOLTC) may also make unannounced monitoring visits to determine the level of satisfaction of those people who receive licensed assisted living services. The OOLTC will share their findings with MDH.

g. Follow-up Evaluation: At the time of the follow-up evaluation, MDH may pursue additional enforcement actions, up to and including immediate temporary suspension or revocation of the license if MDH identifies any level 3 or 4 violations or widespread care related violations.

h. Corrective Action Plan: Scandia Capital Partners LLC will develop and work within a corrective action plan (CAP). The CAP is a working document that includes at least the following information:

i. A statement of the concern
ii. A description of what will happen to correct the concern
iii. A target date for when each correction will be complete
iv. Who is responsible to make sure it happens
v. Current status of correction work
vi. Description of a plan to monitor and ensure ongoing substantial compliance for each corrected order

RESULTS OF FOLLOW-UP EVALUATION DURING THE CONDITIONAL LICENSE PERIOD:
MDH will determine if Scandia Capital Partners LLC is in substantial compliance based on the results of the follow up evaluation. MDH will make this determination within the 90-day conditional license period. If MDH determines Scandia Capital Partners LLC is in substantial compliance on the follow up evaluation, MDH will remove the conditions from Scandia Capital Partners LLC's assisted living facility license, and Scandia Capital Partners LLC will correct violations identified during the evaluation to come into substantial compliance. If MDH determines Scandia Capital Partners LLC is not in substantial compliance, MDH may take additional enforcement action against Scandia Capital Partners LLC, including placement of additional conditions, issuing a second conditional license, or employ any of the enforcement tools listed in Minn. Stat. § 144G.20 up to and including immediate temporary suspension and revocation.

REQUESTING A HEARING:
Pursuant to Minn. Stat. §144G.20, Subd. 17 (c), the licensee may appeal an order immediately temporarily suspending a license or issuing a conditional license. The appeal must be made in writing by certified mail or personal service. If mailed, the appeal must be postmarked and sent to the commissioner within five calendar days after the license holder receives notice. If an appeal is made by personal service, it must be received by the commissioner within five calendar days after the license holder received the order. The request for hearing should be addressed to:

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

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this notice and the results of this visit with the President of your organization's Governing Body.

If you have any questions, please contact Jessica Chenze directly at: 218-332-5175.

Sincerely,

Maria King, RN
Division Director

Minnesota Department of Health
Health Regulation Division

HHH

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	30495	A. BUILDING: _____ B. WING _____	12/07/2022

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0 000	Initial Comments 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: SL#30495015 On December 5, 2022 through December 7, 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, there were seven (7) residents receiving services under the provider's Assisted Living with Dementia Care license. Immediate correction orders were identified on December 6, 2022, issued for SL#30495015, tag identifications 0110, 0495, 1290, 1750 and 2070. On December 7, 2022, at approximately 11:00 a.m., the surveyor exited the facility. As of the time of exit, immediacy remained in effect for all issued immediate correction orders: 0110, 0495, 1290, 1750 and 2070.	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 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.	

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0 110	Continued From page 1	0 110		
0 110 SS=I	144G.10 Subdivision 1a Assisted living director license required Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the licensee had a licensed assisted living director (LALD). This had the potential to affect all the licensee's residents, staff, and visitors. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). This resulted in a correction order on December 6, 2022, at approximately 8:00 a.m. The findings include: The licensee lacked an LALD to oversee the facility. On December 5, 2022, at 9:30 a.m., community coordinator (CC)-A stated she was not sure who the LALD was for the facility. On December 5, 2022, at 2:27 p.m., regional	0 110		

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0 110	Continued From page 2 director/licensed practical nurse (RD/LPN)-D stated she had a LALD license, however, was not affiliated with this site at this time. RD/LPN-D state they have been looking for a LALD for this site since the previous LALD left a little over a month ago, but have not found one. No further information was provided. TIME PERIOD OF CORRECTION: IMMEDIATE On December 7, 2022, at approximately 11:00 a.m., the surveyor exited the facility. As of the time of exit, immediacy remained in effect for immediate correction order 0110.	0 110		
0 250 SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter;	0 250		

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0 250	Continued From page 3 (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to show they met the requirements of licensure, by attesting the managerial officials who oversaw the day-to-day operations understood applicable statutes and rules; nor developed and/or implemented current policies and procedures as required with records	0 250		

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0 250	Continued From page 4 reviewed. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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 5, 2022, at 9:29 a.m., owner(O)-E returned the surveyors phone call. O-E stated they did not have a licensed assisted living director and registered nurse. The surveyor questioned O-E about who the surveyor should call regarding questions during the survey. O-E stated he would not be much help and he would have the regional director/licensed practical nurse (RD/LPN)-D call the surveyor. The licensee's Application for Assisted Living License, section titled Official Verification of Owner or Authorized Agent, (page four and five of the application), identified, I certify I have read and understand the following: [a check mark was placed before each of the following]: - I have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section] 144G.45, my building(s) must comply with subdivisions 1-3 of the section, as applicable section Laws 2020, 7th Spec. [special] Sess [session]., chpt. [chapter] 1. art. [article] 6, sect. 17.	0 250		

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0 250	Continued From page 5 - I have read and fully understand Minn. Stat. sect. 144G.80, 144G.81. and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22, my building(s) must comply with these sections if applicable. - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G. - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659. - Reporting of Maltreatment of Vulnerable Adults. - Electronic Monitoring in Certain Facilities. - I understand pursuant to Minn. Stat. sect. 13.04 Rights of Subjects of Data, the Commissioner will use information provided in this application, which may include an in-person or telephone conference, to determine if the applicant meets requirements for assisted living licensing. I understand I am not legally required to supply the requested information; however, failure to provide information or the submission of false or misleading information may delay the processing of my application or may be grounds for denying a license. I understand that information submitted to the commissioner in this application may, in some circumstances, be disclosed to the appropriate state, federal or local agency and law enforcement office to enhance investigative or enforcement efforts or further a public health protective process. Types of offices include Adult Protective Services, offices of the ombudsmen, health-licensing boards, Department of Human Services, county or city attorneys' offices, police, local or county public health offices. - I understand in accordance with Minn. Stat.	0 250		

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0 250	Continued From page 6 sect. 144.051 Data Relating to Licensed and Registered Persons (opens in a new window), all data submitted on this application shall be classified as public information upon issuance of a provisional license or license. All data submitted are considered private until MDH issues a license. - I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659 governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. - I have examined this application and all attachments and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct, and complete. I will notify MDH, in writing, of any changes to this information as required. - I attest to have all required policies and procedures of Minn. Stat. chapter 144G and Minn. Rules chapter 4659 in place upon licensure and to keep them current as applicable. Page five was electronically signed by RD/LPN-D on May 12, 2022. The licensee had an assisted living license issued on August 1, 2022, with an expiration date of April 30, 2023.	0 250		

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0 250	Continued From page 7 The licensee failed to ensure the following policies and procedures were implemented: (1) orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; (2) conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate; (3) infection control practices; (4) conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards; (5) medication and treatment management; (6) delegation of tasks by registered nurses or licensed health professionals; On December 5, 2022, 2:08 p.m., the surveyor called O-E to let him know that RD/LPN-D had not yet called the surveyor. O-E gave the surveyor RD/LPN-D's phone number. The surveyor called RD/LPN-D and left a message to have her return the surveyor's call. At 2:27 p.m., RD/LPN-D returned the surveyor's call. RD/LPN-D requested the surveyor email her the list of information needed. The surveyor emailed RD/LPN-D the list of information needed. On December 7, 2022, at 8:12 a.m., the surveyor called O-E inquiring about doing an exit conference. O-E stated he was two hours away and he had meetings he had to attend. As of December 7, 2022, at 11:00 a.m., RD/LPN-D had not provided any of the requested	0 250		

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0 250	Continued From page 8 information. As a result of this survey, the following orders were issued 0110, 0250, 0340, 0430, 0450, 0470, 0480, 0495, 0510, 0580, 0630, 0650, 0660, 0680, 0730, 0790, 0800, 0810, 0900, 1290, 1370, 1380, 1420, 1440, 1620, 1650, 1710, 1750, 1760, 1790, 1910, 2040, 2070, 2110, 2170 and 2410, indicating the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.08 to 144G.95. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 250		
0 340 SS=I	144G.30 Subd. 5 Correction orders (a) A correction order may be issued whenever the commissioner finds upon survey or during a complaint investigation that a facility, a managerial official, or an employee of the facility is not in compliance with this chapter. The correction order shall cite the specific statute and document areas of noncompliance and the time allowed for correction. (b) The commissioner shall mail or e-mail copies of any correction order to the facility within 30 calendar days after the survey exit date. A copy of each correction order and copies of any documentation supplied to the commissioner shall be kept on file by the facility and public documents shall be made available for viewing by any person upon request. Copies may be kept electronically. (c) By the correction order date, the facility must document in the facility's records any action taken	0 340		

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0 340	Continued From page 9 to comply with the correction order. The commissioner may request a copy of this documentation and the facility's action to respond to the correction order in future surveys, upon a complaint investigation, and as otherwise needed. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have sufficient documentation with actions taken to comply with the immediate order, tag identification 0110, 0495, 1290, 1750, and 2070, during a survey completed on December 7, 2022. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On December 7, 2022, the Minnesota Department of Health (MDH) completed a survey resulting in 35 correction orders issued and immediate orders 0110, 0495, 1290, 1750, and 2070 issued on December 6, 2022. On December 6, 2022, at 8:38 a.m., owner (O)-E was notified via email by MDH of immediate correction orders for tags 0110, 0495, and 2070. On December 6, 2022, at 8:44 a.m., O-E responded via email that O-E believed the	0 340		

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0 340	Continued From page 10 immediate correction orders were corrected already and regional director/licensed practical nurse (RD/LPN)-D would be getting "everything you need." On December 6, 2022, at 1:00 p.m., O-E was notified via email by MDH of immediate correction orders for tags 1290 and 1750. On December 7, 2022, at 7:58 a.m., O-E was requested via email by MDH to confirm a plan of correction had not yet been received. A response was not received. On December 7, 2022, at approximately 11:00 a.m., the immediacy of all immediate orders identified remained as the survey was exited. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 340		
0 430 SS=C	144G.40 Subd. 2 Uniform checklist disclosure of services (a) All assisted living facilities must provide to prospective residents: (1) a disclosure of the categories of assisted living licenses available and the category of license held by the facility; (2) a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and (3) an oral explanation of the services offered under the contract.	0 430		

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0 430	Continued From page 11 (b) The requirements of paragraph (a) must be completed prior to the execution of the assisted living contract. (c) The commissioner must, in consultation with all interested stakeholders, design the uniform checklist disclosure form for use as provided under paragraph (a). This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a copy of the uniform checklist disclosure of services (UDALSA) with the required content for two of two residents (R1, R2). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 R1's diagnoses included atrial fibrillation, and chronic kidney disease. R1's service plan dated August 2, 2021, indicated the resident received the following services: medication administration, assistance with shower, dressing, grooming, laundry housekeeping and safety checks every two (2) hours. R2 R2's diagnoses included: Alzheimer's disease.	0 430		

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0 430	Continued From page 12 R2's service plan dated November 2, 2021, indicated the resident received the following services: medication administration, assistance with showers, housekeeping, laundry and safety checks every two (2) hours. R1 and R2's record lacked evidence the resident received a copy of the licensee's UDALSA to include: - a disclosure of the categories of assisted living licenses available and the category of license held by the facility; and - a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide. On December 5, 2022, at 9:30 a.m., the surveyor asked community coordinator (CC)-A for a copy of the licensee's UDALSA for review. CC-A stated she was not sure if the licensee had a UDALSA. On December 6, 2022, at 2:00 p.m., community coordinator (CC)-A stated R1 and R2's records lacked documentation to indicated R1 and R2 had received the UDALSA. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 430		
0 450 SS=C	144G.41 Subdivision 1 Minimum requirements All assisted living facilities shall: (1) distribute to residents the assisted living bill of	0 450		

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0 450	Continued From page 13 rights; (2) provide services in a manner that complies with the Nurse Practice Act in sections 148.171 to 148.285; (3) utilize a person-centered planning and service delivery process; (4) have and maintain a system for delegation of health care activities to unlicensed personnel by a registered nurse, including supervision and evaluation of the delegated activities as required by the Nurse Practice Act in sections 148.171 to 148.285; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide the current bill of rights for assisted living to two of two residents (R1, R2) with records reviewed. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: R1 R1 admitted for services on January 19, 2016, under the comprehensive home care license and began receiving assisted living services on August 1, 2021. R1's record lacked evidence R1 had received the Assisted Living Bill of Rights.	0 450		

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0 450	Continued From page 14 R2 R2 admitted for services on November 3, 2020, under the comprehensive home care license and began receiving assisted living services on August 1, 2021. R2's record lacked evidence R2 had received the Assisted Living Bill of Rights. On December 6, 2022, at 2:00 p.m., community coordinator (CC)-A stated R1, R2 and all residents receiving assisted living services had not received the Assisted Living Bill of Rights. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 450		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or	0 470		

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0 470	Continued From page 15 safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the staffing plan was developed and posted as required, potentially affecting all seven (7) residents in the assisted living with dementia care facility, staff and any visitors of the licensee. 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 failed to develop and implement a staffing plan for determining its staffing level based on the following: -each resident's needs, as identified in the resident's service plan and assisted living contract; -each resident's acuity level, as determined by the most recent assessment or individualized	0 470		

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0 470	Continued From page 16 review; -the ability of staff to timely meet the resident's scheduled and reasonably foreseeable unscheduled needs given the physical layout of the facility premises; and -whether the facility has a secured dementia care unit; and staff experience, training, and competency. On December 5, 2022, at 9:30 a.m., community coordinator (CC)-A was questioned regarding the staffing plan. CC-A stated she was not familiar with the need for a staffing plan. CC-A also stated the daily staffing schedule was not posted. On December 5, 2022, at 2:27 p.m., the surveyor spoke to the regional director/licensed practical nurse (RD/LPN)-D by phone regarding the licensee's staffing plan. RD/LPN stated the licensee did not have a staffing plan. The surveyor also emailed RD/LPN requesting a staffing plan policy. As of December 7, 2022, at 11:00 a.m., the surveyor had not received the requested information from RD/LPN-D. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 470		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the	0 480		

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0 480	Continued From page 17 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 according to the Minnesota Food Code. This had the potential to affect all 7 residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated December 5, 2022, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		

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0 495	Continued From page 18	0 495		
0 495 SS=I	144G.41 Subd. 1 (14) Minimum Requirements (14) provide staff access to an on-call registered nurse 24 hours per day, seven days per week. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure that a registered nurse (RN) was available on-call 24 hours a day, seven days per week. This had the potential to affect all seven (7) residents and staff of the facility. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). This resulted in a correction order on December 6, 2022, at approximately 8:00 a.m. The findings include: On December 5, 2022, at 9:29 a.m., owner/agent (O/A)-E returned the surveyor's call. O/A-E stated at this time they did not have a RN. O/A-E stated he hired a RN, but she has not started work yet, as she had to give notice at her previous job. On December 5, 2022, at 9:45 a.m., the surveyor asked community coordinator (CC)-A who the RN was. CC-A stated they have not had a RN in the facility in over a month. CC-A stated the last day a RN was on site was October 31, 2022. CC-A	0 495		

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0 495	Continued From page 19	0 495		

stated if there was a emergency and need to call someone, CC-A would either call regional director/licensed practical nurse (RD/LPN)-D or a LPN at another facility. CC-A stated she did not have a phone number of a RN to call.

On December 5, 2022, at 2:27 p.m., RD/LPN-D stated they hired a RN last week, but she has not started yet as she needed to give notice at her previous employment.

R2's Incident Report dated November 14, 2022, at 9:45 a.m. indicated R3 came to the office and asked CC-A come wake up R2. R2 had fallen asleep in a chair in R3's apartment. When CC-A got to R3's apartment R2 was on the floor. CC-A checked R2's vital signs and asked her a series of questions to make sure she was OK. No injuries were noticed. Used gait belt to assist R2 up off of the floor. CC-A notified on call LPN on November 14, 2022, at 10:00 a.m. R2's record lacked evidence a RN had assessed the resident's condition after the fall and for causal factors of the fall.

R1 and R2's record lacked documentation of reassessment by the RN every 90-days.

R1 was admitted for services on January 13, 2016.

R1's service plan dated August 2, 2021, indicated R1 received the following services: medication management, assistance with shower, dressing, grooming, housekeeping, laundry, and safety checks every two hours.

R1's record contained one RN assessment that was dated January 31, 2022.

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0 495	Continued From page 20 R2 was admitted for services on November 3, 2020. R2's service plan dated November 12, 2021, indicated R2 received the following services: medication management, assistance with showers, housekeeping, laundry, and safety checks every two hours. R2's record only contained one assessment that was dated January 31, 2022. On December 5, 2022, at 2:00 p.m., CC-A confirmed R1 and R2's records only contained one RN assessment that were both dated January 31, 2022. On December 5, 2022, at 2:27 p.m., RD/LPN-D stated the RN assessment should be in the resident records. RD/LPN-D stated she just got access to the previous RN's computer, and she does not know if there are assessments in the computer for these two residents. No further information was provided. TIME PERIOD OF CORRECTION: IMMEDIATE On December 7, 2022, at approximately 11:00 a.m., the surveyor exited the facility. As of the time of exit, immediacy remained in effect for immediate correction order 0495.	0 495		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control.	0 510		

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0 510	Continued From page 21 (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) 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 establish and maintain an effective infection control program to comply with accepted health care, medical, and nursing standards for infection control and current recommendations for COVID-19 regarding wearing appropriate personal protective equipment (PPE). In addition, the licensee failed to ensure reusable equipment was cleaned in-between resident use. This had the potential to affect all seven 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: PPE On December 5, 2022, at 9:30 a.m., the community coordinator (CC)-A, cook (C)-B, and activities (A)-C were observed to be interacting with residents not wearing masks. The surveyor	0 510		

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0 510	Continued From page 22 observed CC-A, C-B and A-C throughout the day not to be wearing masks. On December 6, 2022, at 6:36 a.m., the surveyor observed unlicensed personnel (ULP)-G to only wearing a face mask while providing medication administration (including eye drops) and application of compression stockings for R4. ULP-G confirmed he did not wear eye protection while providing cares to R4. On December 6, 2022, at 2:00 p.m., CC-A confirmed CC-A, C-B and A-C, did not wear face masks on December 5, 2022. The licensee's Covid-19 Pandemic Emergency Action Plan last reviewed October 27, 2021, indicated while at work staff are to: -wear medical grade mask or N95 masks when passing medications, working with food, and/or doing cares with clients; and -wear goggles/face shields/side shields on personal glasses in all resident care areas or while providing direct personal cares. CDC (Center for Disease Control and Prevention) COVID-19 Data Tracker, for community level rate for St Louis County was "low" during the survey. DISINFECTING REUSABLE EQUIPMENT On December 6, 2022, at 6:55 a.m., the surveyor observed ULP-G perform blood pressure, oxygen saturation monitoring and weight for on R5. After ULP-G completed the procedures, ULP-G returned the blood pressure machine, to its case, the oxygen saturation monitor to the drawer in the medication cart, and the scale under the table in the office. ULP-G did not disinfect the equipment prior to putting the equipment away. ULP-G	0 510		

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0 510	Continued From page 23 confirmed ULP-G did not disinfect the blood pressure machine, oxygen saturation monitor, or the scale after using the equipment on R5. On December 6, 2022, at 2:00 p.m., the surveyor requested a policy addressing disinfecting reusable equipment. The policy was not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to engage in and maintain documentation of quality management activity. This had the potential to affect all seven (7) residents receiving assisted living services. This practice resulted in a level two violation (a	0 580		

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0 580	Continued From page 24 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: On December 5, 2022, at 9:30 a.m., the surveyor asked community coordinator (CC)-A to provide the licensee's quality management policy and documentation of quality management activity. On December 6, 2022, at 2:00 p.m., CC-A- stated the licensee had a quality management policy and documentation of quality management activities, but CC-A was unable to find either. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 580		
0 630 SS=E	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the	0 630		

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0 630	Continued From page 25 abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan was developed to include the required content for two of two residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1 R1's diagnoses included atrial fibrillation, and chronic kidney disease. R1's service plan dated August 2, 2021, indicated the resident received the following services: medication administration, assistance with shower, dressing, grooming, laundry housekeeping and safety checks every two (2) hours. R2 R2's diagnoses included: Alzheimer's disease. R2's service plan dated November 2, 2021, indicated the resident received the following	0 630		

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0 630	Continued From page 26 services: medication administration, assistance with showers, housekeeping, laundry and safety checks every two (2) hours. R1 and R2's records lacked documentation to indicate an Individualized Abuse Prevention Plan had been developed to include the following content: -individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; -the person's risk of abusing other vulnerable adults; -the person's risk at abusing self; and -statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. On December 5, 2022, at 2:27 p.m., the surveyor requested information pertaining to R1 and R2's individual abuse prevention plans from regional director/licensed practical nurse (RD/LPN)-D. As of December 7, 2022, at 11:00 a.m. RD/LPN-D had not provided any information pertaining to R1 and R2's individual abuse prevention plans. On December 6, 2022, at 2:00 p.m., community coordinator (CC)-A stated R1 and R2's records did not include a individualized abuse prevention plan. A policy was requested and not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 630		

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0 650	Continued From page 27	0 650		
0 650 SS=E	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. (b) Each employee record must be retained for at least three years after a paid employee, volunteer, or contractor ceases to be employed by, provide services at, or be under contract with the facility. If a facility ceases operation, employee records must be maintained for three years after facility operations cease. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure two of three employee records (unlicensed personnel (ULP)-G, ULP-H) included a job description. In	0 650		

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0 650	Continued From page 28 addition, the licensee failed to ensure one of one employee records (ULP)-I contained a job description that included the identification of the staff person providing supervision. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: ULP-G and ULP-H's employee records lacked a job description. ULP-G was hired on September 6, 2022, to provided direct care under the licensee's assisted living with dementia care license. On December 6, 2022, at 6:36 a.m., the surveyor observed ULP-G administer R4's morning medications. ULP-H was hired on May 24, 2022, to provide direct care under the licensee's assisted living with dementia care license. On December 6, 2022, throughout the day was observed to provide direct care to several residents. ULP-I was hired on October 7, 2002. to provide direct care under the licensee's assisted living with dementia care license. ULP-I's employee record contained a job	0 650		

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0 650	Continued From page 29 description signed October 4, 2022, did not include the identification of the staff person providing supervision. On December 6, 2022, at 2:00 p.m., community coordinator (CC)-A stated ULP-G and ULP-H's employee records lacked a current job description and the job description in ULP-I's employee record did not include identification of the staff person providing supervision. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	0 660		

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0 660	Continued From page 30 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 ensure a TB Risk Assessment was completed; failed to ensure a TB history and symptom screen were completed for three of three employees (unlicensed personnel (ULP)-G, ULP-H, ULP-I) and screening for active TB (either a two-step tuberculin skin test (TST) or blood test) were completed and documented for one of three employees (ULP-G). 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: TB RISK ASSESSMENT On December 5, 2022, at 9:30 a.m., the surveyor requested a TB Risk Assessment from community coordinator (CC)-A. CC-A stated she was not familiar with a TB Risk Assessment. On December 5, 2022, at 2:27 p.m., the surveyor, by email, requested a TB Risk assessment from regional director/licensed practical nurse (RD/LPN)-D. As of December 7, 2022, at 11:00 a.m. RN/LPN-D had not provided a TB Risk assessment. TB HISTORY AND SYMPTOM SCREEN AND/OR TST MONITORING	0 660		

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0 660	Continued From page 31 ULP-G ULP-G was hired on September 6, 2022, to provide direct care services under the licensee's assisted living with dementia care license. On December 6, 2022, at 6:36 a.m., the surveyor observed ULP-G administer R4's morning medications. ULP-G's employee record lacked evidence a TB history and symptom screen and TST had been completed. ULP-H ULP-H was hired on May 24, 2022, to provide direct care services under the licensee's assisted living with dementia care license. On December 6, 2022, throughout the day ULP-H was observed to provide direct care services to several residents. ULP-H's employee record lacked evidence a TB history and symptom screen had been completed. ULP-I ULP-I was hired on October 7, 2022, to provide direct care services under the licensee's assisted living with dementia care license. R1's November 2022 medication administration record indicated ULP-I had administered R1's medications on several days. ULP-I's employee record lacked evidence a TB history and symptom screen had been completed. On December 6, 2022, at 2:00 p.m., CC-A stated	0 660		

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0 660	Continued From page 32 ULP-G's employee record lacked evidence ULP-G had completed a TB history and symptom screen and TST. CC-A stated ULP-H and ULP-I's employee records did not contain a TB history and symptom screen. The licensee's Tuberculosis Screening/Prevention policy dated August 1, 2021, indicated [facility name] will observe the recommended precautions related to TB prevention as identified by the Centers for Disease Control and Prevention (CDC) and the Minnesota Department of Health (MDH). The precautions include the following elements: -Risk Assessment; -Frequency of Screening; and -Serial Testing. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor;	0 680		

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0 680	Continued From page 33 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 to have a written emergency disaster plan with all required content and failed to post an emergency plan prominently. This had the potential to affect all residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On December 5, 2022, at 1:00 p.m., the surveyor requested the licensee's emergency preparedness plan from community coordinator (CC)-A. CC-A stated the emergency plan was not posted prominently.	0 680		

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0 680	Continued From page 34 On December 6, 2022, at 2:00 p.m., CC-A stated the licensee did not have an emergency preparedness plan that included the following required content: -a risk assessment for the facility; - a comprehensive program to include infectious diseases and pandemics; - a description of the population served by the licensee; - process for emergency preparedness (EP) cooperation with state and local EP officials/organizations; - procedure for tracking staff and residents; - subsistence needs for staff and residents during emergency situation; - development of policies/procedures to address: - evacuation plan (not customized for the facility); - fire (not customized for the facility) - shelter in place; - a tracking system used to document locations or residents and staff - the medical record documentation system to preserve resident information - emergency staff strategies - the facility's role in providing care and treatment at alternative sites -missing persons - a communication plan that included: - arrangement with other facilities - names and contact information for staff, resident physicians, other facilities - contact information for federal, state, tribal, local EP staff, ombudsman - primary and alternative means for communicating with facility staff, federal, state, regional and local emergency management agencies - a method of sharing information and	0 680		

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0 680	Continued From page 35 medical documentation for residents - a means to provide information regarding the facility's needs, and its ability to provide assistance to include information about their occupancy -a method of sharing information from the emergency plan with residents and their families - EP training and testing program - EP training program for staff (including documentation of training provided) - EP testing/annual testing requirements. A policy was requested, but not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 730 SS=E	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives,	0 730		

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0 730	Continued From page 36 guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident record contained documentation of the services being provided for two of two residents (R1 and R2) and failed to ensure documentation of significant changes in the resident's status and actions taken in response to the needs of the resident for two of two residents (R1 and R2).	0 730		

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0 730	Continued From page 37 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: DOCUMENTATION OF SERVICES R1 R1 service plan dated August 2, 2021, indicated services included medication administration, assistance with showers two (2) times a week, dressing daily, grooming a.m. and p.m., weekly laundry and housekeeping, and safety checks every two (2) hours. R1's Daily Monitoring Flowsheet for October 2022, indicated the unlicensed personnel (ULP) documented the services as follows: -shower assistance three (3) out of eight (8) opportunities; -dressing zero out of thirty-one (31) opportunities; -grooming a.m. and p.m. zero out of sixty-two (62) opportunities; -laundry zero out of four (4) opportunities; -housekeeping zero out of four (4) opportunities; and -safety checks zero out of three hundred and seventy-two (372) opportunities. R1's Daily Monitoring Flowsheet for November 2022, indicated the ULP documented the services as follows:	0 730		

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0 730	Continued From page 38 -shower assistance three (3) out of eight (8) opportunities; -dressing zero out of thirty (30) opportunities; -grooming a.m. and p.m. zero out of sixty (60) opportunities; -laundry zero out of four (4) opportunities; -housekeeping zero out of four (4) opportunities; and -safety checks zero out of three hundred and sixty (360) opportunities. R1's Daily Monitoring Flowsheet for December 2022, indicated the ULP documented the services as follows: -dressing zero out of five (5) opportunities; -grooming a.m. and p.m. zero out of ten (10) opportunities; -laundry zero out of one (1) opportunity; -housekeeping zero out of one (1) opportunity; and -safety checks zero out of sixty (60) opportunities. R2 R2's service plan dated November 2, 2021, indicated services included medication administration, shower two times a week, weekly housekeeping and laundry, and safety checks every two hours. R2's Daily Monitoring Flowsheet for December 2022, indicated the ULP documented the services as follows: -laundry zero out of one (1) opportunity; -housekeeping zero out of one (1) opportunity; and -safety checks zero out of sixty (60) opportunities. On December 6, 2022, at 2:00 p.m. community coordinator (CC)-A stated R1 and R2's services were provided. CC-A confirmed R1 and R2's	0 730		

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0 730	Continued From page 39 services were not documented on the Daily Monitoring Flowsheet as indicated above. DOCUMENTATION OF SIGNIFICANT CHANGES IN THE RESIDENT'S STATUS AND ACTION TAKEN On December 5, 2022, at 11:30 a.m. CC-A provided the surveyor two incident reports for review. R1 R1's Incident Report dated October 28, 2022, at 10:05 a.m. (written by ULP), indicated R1 was out of the shower and on her way to her room to dress. I stepped out of the room to get cleaning supplies and on my way back I heard her call out that I fell. R1 was trying to remove shower cap and put towel over her shoulders. LPN (licensed practical nurse) was notified. The follow up area on the incident report was completed on October 30, 2022, by a LPN. Resident denies pain. Advised staff to stay with resident until sitting before leaving the room in the future. R1's record lacked documentation pertaining to R1's fall on October 28, 2022, and any action taken. R2 R2's Incident Report dated November 14, 2022, 9:45 a.m. (written by ULP) indicated R6 came to the office to ask staff to come to her room as R2 had fallen asleep on a chair in her room. When staff got to the room R2 was on the floor. Staff asked her a series of questions and used a gait belt to get her up off the floor. On November 14, 2022, at 10:00 a.m., staff notified the on-call LPN.	0 730		

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0 730	Continued From page 40 At 11:00 a.m., staff scanned and emailed R2's incident report to the on-call LPN. R2's record lacked documentation pertaining to R2's fall on November 14, 2022, and any action taken. On December 6, 2022, at 2:00 p.m., CC-A stated the incident reports are not a part of the resident's record. CC-A stated R1 and R2's records lacked documentation to R1 and R2's falls. The licensee's Client Records policy dated May 9, 2019, indicated the client's record included the following: -documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; and -documentation that services have been provided as identified in the service plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730		
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; (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	0 790		

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0 790	Continued From page 41 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 provide portable fire extinguishers that were readily accessible to all occupants within the facility. 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 the potential to affect a large portion or all residents). The findings include: On December 5, 2022, at approximately 11:30 a.m., survey staff toured the facility with Activities Director (A)-B. During the facility tour, survey staff observed the required fire extinguisher was located in an unlabeled closet and was not readily visible and accessible for use. A-B verbally confirmed survey staff observations during the facility tour. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 790		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment	0 800		

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0 800	Continued From page 42 (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 maintain the facility physical environment in a continuous state of good repair and operation regarding 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 or has the potential to affect a large portion or all residents). The findings include: On December 5, 2022, at approximately 11:30 a.m., survey staff toured the facility with Activities Director (A)-B Findings include: A grab bar in the shower in resident room 1 had detached mounting screw covers creating sharp edges and risk of injury to the occupant. Storage and shelving in the closet at the end of	0 800		

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0 800	Continued From page 43 the corridor adjacent to resident room 3 were observed obstructing the electrical panel located in the closet. Electrical panels are required to have ready access and not be obstructed with storage and other objects. Combustible items were observed on the hearth and in contact with the glass of the gas fireplace in the common living room area. The exterior intake vents for the building air exchanger were dirty and would not allow fresh air into the building as designed for indoor air quality. Only one of the building air exchangers supplying fresh air to the facility for indoor air quality was plugged in and operating. The other air exchanger was unplugged and not operating as designed to maintain indoor air quality. It was observed one of the air exchangers in the mechanical room is powered by an extension cord. Extension cords are intended for temporary power, not as a replacement for permanent wiring. During the tour it was observed the required annual service of the fire alarm system had not been documented. A-B visually verified the documentation was not available. A sprinkler head in the bathroom closet in resident room 6 was observed covered with paper masking, which will reduce its effectiveness in the event of a fire. The bath fan vent cover in resident room was covered with excessive lint reducing its ability to ventilate the bathroom.	0 800		

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0 800	Continued From page 44 A-B verbally confirmed survey staff observations during the facility tour. TIME PERIOD FOR CORRECTION: Twenty-one (21) 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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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCANDIA CAPITAL PARTNERS LLC	102 NORTH 58TH AVENUE WEST DULUTH, MN 55807

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0 810	Continued From page 45 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: Records were requested and an interview was conducted on December 5, 2022, at approximately 12:15 p.m. of Community Coordinator (CC)-A and Activities Director (A)-B on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. 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: Record review of the available documentation indicated that the licensee did not maintain the fire safety and evacuation plan for the facility. CC-A was not able to provide documentation of the fire safety and evacuation plan. The documentation provided of posted fire safety and evacuation floor plan was not clear enough to read. The plan must show location and number of resident rooms. Record review of the available documentation indicated that the licensee did not have specific employee actions to be taken in the event of a fire or similar emergency.	0 810		

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0 810	Continued From page 46 Record review of the available documentation indicated that the licensee did not have fire protection procedures necessary for residents included in the fire safety and evacuation plan. Record review of the available documentation indicated that the fire safety and evacuation plan did not include 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. Record review of the available documentation indicated that employees did not receive training upon initial hire and twice per year thereafter on the facility fire safety and evacuation plan. The fire safety and evacuation plan was not available at all times within the facility for the use of staff and occupants for guidance during an emergency. Record review of the available documentation indicated that the licensee did not provide training to residents who are capable of self-evacuation on the proper actions to be taken in the event of a fire in regard to movement, evacuation, and relocation. Record review of the available documentation did not indicate that evacuation drills had been conducted twice per year per shift and least once every other month as required. All deficiencies were verified by CC-A during the interview at approximately 12:15 p.m. TIME PERIOD FOR CORRECTION: Twenty-one	0 810		

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0 810	Continued From page 47 (21) days.	0 810		
0 900 SS=E	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing	0 900		

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0 900	Continued From page 48 contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and execute a written assisted living contract with the required content for two of two residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1 R1's diagnoses included Atrial fibrillation, and chronic kidney disease. R1's service plan dated August 2, 2021, indicated the resident received the following services: medication administration, assistance with showers, dressing, grooming, housekeeping, laundry, and safety checks every two (2) hours. R2 R2's diagnoses included Alzheimer's disease. R2's service plan dated November 2, 2021, indicated the resident received the following services: medication administration, assistance with shower, housekeeping, laundry, and safety checks every two (2) hours.	0 900		

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0 900	Continued From page 49 R1 and R2's records lacked a written contract which included the terms concerning the provisions of the following as required: (1) housing (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement. In addition, R1 and R2's records lacked evidence that the contract had been fully executed as the facility must: - give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed; and - the facility must offer the resident the opportunity to identify a designated representative. On December 5, 2022, at 2:27 p.m., the surveyor requested information pertaining to R1 and R2's assisted living contracts from regional director/licensed practical nurse (RD/LPN)-D. As of December 7, 2022, at 11:00 a.m. RD/LPN-D had not provided any information pertaining to R1 and R2's assisted living contracts. On December 6, 2022, at 2:00 p.m. community coordinator (CC)-A stated R1 and R2's records lacked evidence an assisted living contract had been completed for R1 and R2. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 900		

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01290	Continued From page 50	01290		
01290 SS=G	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to affiliate background studies to the facility license for one of four staff, unlicensed personnel (ULP)-H. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: This resulted in an immediate order for correction on December 6, 2022.	01290		

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01290	Continued From page 51 The findings include: ULP-H was hired on May 24, 2022, to provide direct care services to the licensee's residents. ULP- employee record contained a background study submitted by a separate location operated by the licensee, dated May 27, 2022. ULP-H's employee record lacked evidence the licensee submitted a background study for their license or affiliated the background study with this license. On December 6, 2022, at 11:54 a.m., the surveyor verified with licensee staff through Department of Human Services Net Study 2.0 the following: - There was no cleared background study or pending application in Net Study 2.0 for ULP-H under the licensee's name or license number. The licensee's Background Check policy last revised February 14, 2022, indicated candidate in [state name] will undergo background checks via the Minnesota Department of Human Services. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate On December 7, 2022, at approximately 11:00 a.m., the surveyor exited the facility. As of the time of exit, immediacy remained in effect for immediate correction order 1290.	01290		
01370 SS=F	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn	01370		

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01370	Continued From page 52 (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 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.	01370		

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01370	Continued From page 53 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure training and competency evaluations included all the required training for three of three employees (unlicensed personnel (ULP)-G, ULP-H, ULP-I). 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: ULP-G ULP-G was hired on September 6, 2022, to provide direct care services under the licensee's assisted living with dementia care license. On December 6, 2022, at 6:35 a.m., the surveyor observed ULP-G administer R4's morning medications. ULP-G's employee record lacked evidence ULP-G had received the following training and competency: - 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; - standby assistance techniques and how to perform them;	01370		

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01370	Continued From page 54 - medication, exercise, and treatment reminders; - 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; and - awareness of commonly used health technology equipment and assistive devices. ULP-H ULP-H was hired on May 24, 2022, to provide direct care services under the licensee's assisted living with dementia care license. On December 6, 2022, throughout the day ULP-H was observed to provide direct care services to several residents. ULP-H's employee record lacked evidence ULP-H had received the following training and competency: - 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; - standby assistance techniques and how to perform them; - medication, exercise, and treatment reminders; - 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; - awareness of confidentiality and privacy; - understanding appropriate boundaries between staff and residents and the resident's family; and - awareness of commonly used health technology equipment and assistive devices.	01370		

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01370	Continued From page 55 ULP-I ULP-I was hired on October 7, 2022, to provide direct care services under the licensee's assisted living with dementia care license. R1's November 2022 Medication Administration Record (MAR) indicated ULP-I administered medications to R1 on several days. ULP-H's employee record lacked evidence ULP-H had received the following training and competency: - maintaining a safe clean environment; - 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; - standby assistance techniques and how to perform them; - medication, exercise, and treatment reminders; - 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; and - awareness of commonly used health technology equipment and assistive devices. On December 6, 2022, at 2:00 p.m., community coordinator (CC)-A stated she was unable to find the above identified training for ULP-G, ULP-H, and ULP-I. The licensee's Staffing Competency policy dated August 1, 2021, indicated training and competency evaluations for all unlicensed personnel, include the following. Unlicensed personnel may not work for [facility name] until	01370		

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01370	Continued From page 56 they have successfully passed the written competency test (at 80%) and demonstration competency evaluation. - maintenance of a clean and safe environment; - 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 iv. dressing and assisting with toileting; - training on the prevention of falls; - standby assistance techniques and how to perform them; - medication, exercise, and treatment reminders; - 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; - awareness of confidentiality and privacy; - understanding appropriate boundaries between staff and residents and the resident's family; and - awareness of commonly used health technology equipment and assistive devices. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		
01380 SS=F	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other	01380		

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01380	Continued From page 57 observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure training and competency evaluations included all the required training for three of three employees (unlicensed personnel (ULP)-G, ULP-H, ULP-I). 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: ULP-G ULP-G was hired on September 6, 2022, to provide direct care services under the licensee's assisted living with dementia care license. On December 6, 2022, at 6:35 a.m., the surveyor observed ULP-G administer R4's morning medications. ULP-G's employee record lacked evidence	01380		

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01380	Continued From page 58 ULP-G had received the following training and competency: - basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; - reading and recording temperature, pulse, and respirations of the resident; - recognizing physical, emotional, cognitive, and developmental needs of the resident; - safe transfer techniques and ambulation; - range of motioning and positioning; and - administering medications or treatments as required. ULP-H ULP-H was hired on May 24, 2022, to provide direct care services under the licensee's assisted living with dementia care license. On December 6, 2022, throughout the day ULP-H was observed to provide direct care services to several residents. ULP-H's employee record lacked evidence ULP-H had received the following training and competency: - basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; - reading and recording temperature, pulse, and respirations of the resident; - recognizing physical, emotional, cognitive, and developmental needs of the resident; - safe transfer techniques and ambulation; - range of motioning and positioning; and - administering medications or treatments as required.	01380		

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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
01380	Continued From page 59 ULP-I ULP-I was hired on October 7, 2022, to provide direct care services under the licensee's assisted living with dementia care license. R1's November 2022 Medication Administration Record (MAR) indicated ULP-I administered medications to R1 on several days. ULP-I's employee record lacked evidence ULP-H had received the following training and competency: - basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; - reading and recording temperature, pulse, and respirations of the resident; - recognizing physical, emotional, cognitive, and developmental needs of the resident; - safe transfer techniques and ambulation; - range of motioning and positioning; and - administering medications or treatments as required. On December 6, 2022, at 2:00 p.m., community coordinator (CC)-A stated she was unable to find the above identified training for ULP-G, ULP-H, and ULP-I. The licensee's Staffing Competency policy dated August 1, 2021, indicated training and competency evaluations for all unlicensed personnel include the following. Unlicensed personnel may not work for [facility name] until they have successfully passed the written competency test (at 80%) and demonstration competency evaluation. - basic knowledge of body functioning and changes in body functioning, injuries, or other	01380		

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01380	Continued From page 60 observed changes that must be reported to appropriate personnel; - reading and recording temperature, pulse, and respirations of the resident; - recognizing physical, emotional, cognitive, and developmental needs of the resident; - safe transfer techniques and ambulation; - range of motioning and positioning; and - administering medications or treatments as required. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380		
01420 SS=D	144G.62 Subd. 2 Delegation of assisted living services (b) When the registered nurse or licensed health professional delegates tasks to unlicensed personnel, that person must ensure that prior to the delegation the unlicensed personnel is trained in the proper methods to perform the tasks or procedures for each resident and is able to demonstrate the ability to competently follow the procedures and perform the tasks. If an unlicensed personnel has not regularly performed the delegated assisted living task for a period of 24 consecutive months, the unlicensed personnel must demonstrate competency in the task to the registered nurse or appropriate licensed health professional. The registered nurse or licensed health professional must document instructions for the delegated tasks in the resident's record. This MN Requirement is not met as evidenced by: Based on observation, interview and record	01420		

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01420	Continued From page 61 review, the licensee failed to ensure the registered nurse (RN) conducted training and competency evaluations for one of one unlicensed personnel (ULP)-G who performed blood pressure monitoring, oxygen saturation monitoring, and weights. 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: ULP-G was hired on September 9, 2022, to provide direct care services under the licensee's assisted living with dementia care license. On December 6, 2022, at 6:55 a.m., the surveyor observed ULP-G perform blood pressure monitoring, oxygen saturation monitoring, and weights on R5. ULP-G's employee record lacked evidence ULP-G had been trained by a RN and demonstrated they were competent to perform blood pressure monitoring, oxygen saturation monitoring and weights. On December 6, 2022, at 2:00 p.m., community coordinator (CC)-A stated ULP-G employee recorded lacked documentation to indicated ULP-G had been trained by a RN and demonstrated they were competent to perform blood pressure monitoring, oxygen saturation	01420		

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01420	Continued From page 62 monitoring and weights. The licensee's Delegation of Assisted Living Services policy dated August 1, 2021, indicated the Registered Nurse or licensed health professional is responsible for appropriately delegating tasks to staff who possess the knowledge and skills consistent with the complexity of the tasks in accordance with the appropriate Minnesota Practice Act. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01420		
01440 SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and	01440		

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01440	Continued From page 63 thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure direct supervision of unlicensed personnel (ULP) performing delegated tasks was completed for three of three employees (ULP-G, ULP-H, ULP-I). 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: ULP-G ULP-G was hired on September 6, 2022, to provide direct care services under the licensee's assisted living with dementia care license. On December 6, 2022, at 6:35 a.m., the surveyor observed ULP-G administer R4's morning medications. ULP-H ULP-H was hired on May 24, 2022, to provide direct care services under the licensee's assisted living with dementia care license. On December 6, 2022, throughout the day ULP-H was observed to provide direct care services to several residents. Including medication	01440		

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01440	Continued From page 64 administration. ULP-I ULP-I was hired on October 7, 2022, to provide direct care services under the licensee's assisted living with dementia care license. R1's November 2022 Medication Administration Record (MAR) indicated ULP-I administered medications to R1 on several days. ULP-G, ULP-H, and ULP-I's employee records lacked evidence direct supervision of ULP performing delegated tasks had been completed by the registered nurse (RN) within 30 days of first performing the delegated tasks. On December 6, 2022, at 2:00 p.m., community coordinator (CC)-A stated ULP-G, ULP-H, and ULP-I's employee record lacked evidence direct supervision of ULP performing delegated tasks had been completed by the RN within 30 days of first performing the delegated tasks The licensee's Supervision-Licensed and Unlicensed Staff policy dated May 9, 2019, indicated direct supervision of unlicensed staff performing delegated tasks will be provided within 30 days after the individual begins working for the assisted living facility and thereafter as needed based on performance. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440		
01620 SS=E	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring	01620		

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01620	Continued From page 65 (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed a comprehensive reassessment after a fall for two of two residents (R1, R2), and failed to ensure the ongoing resident reassessment did not exceed 90 days for two of two residents (R1, R2). In addition, the licensee failed to ensure the RN used the uniform assessment tool when completing the two of two residents (R1, R2) assessments. This practice resulted in a level two violation (a	01620		

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01620	Continued From page 66 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: FALLS R1 R1's diagnoses included: atrial tribulation and chronic kidney disease. R1's service plan dated August 2, 2021, indicated services included medication administration, assistance with showers two (2) times a week, dressing daily, grooming a.m. and p.m., weekly laundry and housekeeping, and safety checks every two (2) hours. R1's Incident Report dated October 28, 2022, at 10:05 a.m. (written by ULP). R1 was out of the shower and on her way to her room to dress. I stepped out of the room to get cleaning supplies and on my way back I heard her call out that I fell. R1 was trying to remove shower cap and put towel over her shoulders. LPN (licensed practical nurse) was notified. The follow up area on the incident report was completed on October 30, 2022, by a LPN. Resident denies pain. Advised staff to stay with resident until sitting before leaving the room in the future. The only Assisted Living-RN Baseline Assessment in R1's record is dated January 31, 2022.	01620		

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01620	Continued From page 67 R1's progress notes indicated the following: -April 7, 2022, indicated R1's prescriber called and order a urinalysis and a sample was sent to the clinic. -November 17, 2022, (written by a LPN) indicated R1 had a bruise on her forearm that was healing. R1's record lacked documentation to indicate the RN reassessed R1 after the fall to include causal factors and develop interventions to reduce further falls. R2 R2's diagnoses include Alzheimer's disease. R2's service plan dated November 2, 2021, indicated services included medication administration, shower two times a week, weekly housekeeping and laundry, and safety checks every two hours. R2's Incident Report dated November 14, 2022, 9:45 a.m. (written by ULP). R6 came to the office to ask staff to come to her room as R2 had fallen asleep on a chair in her room. When staff got to the room R2 was on the floor. Staff asked her a series of questions and used a gait belt to get her up off the floor. On November 14, 2022, at 10:00 a.m., staff notified the on-call LPN. At 11:00 a.m. staff scanned and emailed R2's incident report to the on-call LPN. The only Assisted Living-RN Baseline Assessment in R2's record is dated January 31, 2022. R2's Progress Notes indicated the following: (all written by LPN) -November 8, 2022, doing well R2 has not	01620		

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01620	Continued From page 68 complaints. -November 17, 2022, staff reports bruise on R2's left hip and buttocks. Could be from fall. Nurse practitioner here today and had no concerns. -November 30, 2022, R2 has no concerns or complaints to note. Doing well. R2's record lacked documentation to indicate the RN reassessed R2 after the fall to include causal factors and develop interventions to reduce further falls. 90 DAY REASSESSMENT AND UNIFORM ASSESSMENT TOOL R1 R1's Assisted Living-RN Baseline Assessment Form (2020) dated January 31, 2022, was the only assessment in R1's record. R1's January 31, 2022, assessment did not include all the required components of the uniform assessment tool. R2 R2's Assisted Living-RN Baseline Assessment Form (2020) dated January 31, 2022, was the only assessment in R2's record. R2's January 31, 2022, assessment did not include all the required components of the uniform assessment tool. On December 5, 2022, at 2:27 p.m., the surveyor requested information pertaining to R1 and R2's 90-day assessments and fall assessments from regional director/licensed practical nurse (RD/LPN)-D. As of December 7, 2022, at 11:00 a.m. RD/LPN-D had not provided any information pertaining to R1 and R2's assessments. On December 6, 2022, at 2:00 p.m. community coordinator (CC)-A stated the only assessment in R1' and R2's records were dated January 31, 2022, respectively. In addition, CC-A stated the	01620		

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01620	Continued From page 69 RN had not reassessed R1 and R2 pertaining to their falls. The licensee's Assessment- Comprehensive Services policy dated August 1, 2021, indicated ongoing client monitoring and reassessment must be conducted as needed based on changes in the needs of the client, but cannot exceed 90 days. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01620		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including	01650		

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01650	Continued From page 70 identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the service plans included the required content for two of two residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a 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: R1 R1's service plan dated August 2, 2021, indicated services included medication administration, assistance with showers two (2) times a week, dressing daily, grooming a.m. and p.m., weekly laundry and housekeeping, and safety checks every two (2) hours. On December 6, 2022, at 7:20 a.m., the surveyor observed unlicensed personnel (ULP)-H check R1's temperature and oxygen saturation at the dining room table, with other residents present.	01650		

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01650	Continued From page 71 R2 R2's service plan dated November 2, 2021, indicated services included medication administration, shower two times a week, weekly housekeeping and laundry, and safety checks every two hours. On December 6, 2022, at 7:25 a.m., the surveyor observed ULP-G administer R2's morning medications. R1 and R2's service plans lacked the following required content: -the method of monitoring staff providing services. On December 6, 2022, at 2:00 p.m., community coordinator (CC)-A stated R1, R2 and all other residents service plans did not include the method of monitoring staff providing services. On December 5, 2022, at 9:30 a.m., CC-A provided the surveyor the policy and procedure book. There was not a policy pertaining to service plans in the policy and procedure book provided. On December 5, 2022, at 2:27 p.m., the surveyor requested a service plan policy from director/licensed practical nurse (RD/LPN)-D. As of December 7, 2022, at 11:00 a.m. RD/LPN-D had not provided any information pertaining to service plan policy. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01650		

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01710	Continued From page 72	01710		
01710 SS=E	144G.71 Subd. 3 Individualized medication monitoring and reas The assisted living facility must monitor and reassess the resident's medication management services as needed under subdivision 2 when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the registered nurse (RN) conducted a face-to-face medication management reassessment to include all required content for two of two residents (R1, R2) who received medication management services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On December 5, 2022, at 9:30 a.m., community coordinator (CC)-A stated the licensee provided medication management services to the residents at the facility. R1 R1's diagnoses included: arterial fibrillation,	01710		

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01710	Continued From page 73 chronic kidney disease, and Alzheimer's disease. R1's service plan dated August 2, 2021, indicated the resident received services which included medication administration. R1's prescriber's orders dated June 30, 2022, included two pain medications, one medication to treat irregular heartbeat, one medication to treat breast cancer, one medication to treat Alzheimer's disease, two anti-hypertensive medications, and one vitamin. On December 6, 2022, at 6:45 a.m., the surveyor observed unlicensed personnel (ULP)-G administered R1's morning medications. R1's Medication Management Plan was last reviewed August 2, 2021. R2 R2's diagnoses included Alzheimer's disease. R2's service plan dated November 2, 2021, indicated the resident received services which included medication administration. R2's prescriber's orders dated June 30, 2022, included one to prevent and treat bone loss, two medications to treat Alzheimer's disease, one antidepressant, and four vitamins/supplements. On December 6, 2022, at 7:25 a.m., the surveyor observed ULP-G administer R2's morning medications. R1 and R2's records lacked evidence the RN conducted a review of all medications the residents were known to be taking include a review of the side effects and contraindications	01710		

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01710	Continued From page 74 annually. On December 6, 2022, at 2:00 p.m., CC-A stated R1 and R2's medication manage plans had not been by the RN annually. The licensee's Assessment-Comprehensive Services policy dated August 1, 2021, indicated the RN would review the medication profile. The policy does not address the frequency of the review. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01710		
01750 SS=H	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure competence prior to delegating the nursing task of medication administration, for three of three unlicensed	01750		

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01750	Continued From page 75 personnel (ULP-G, ULP-H, ULP-I) demonstrated competency for administering medications. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a 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). This resulted in an immediate order on December 6, 2022. The findings include: ULP-G ULP-G was hired on September 8, 2022, to provide direct care services under the licensee's assisted living with dementia care license. ULP- G's training record lacked evidence ULP-G had been trained and demonstrated competency in medication administration. On December 6, 2022, at 7:10 a.m., the surveyor observed ULP-G to prepare R 5's morning medications and administer to R5. Medications prepared by ULP-G included: - Docusate 100 mg (milligrams); and - Quetiapine 25 mg. ULP-H ULP-H was hired on May 24, 2022, to provide direct care services under the licensee's assisted living with dementia care license.	01750		

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01750	Continued From page 76 ULP-H's training record lacked evidence ULP-H had been trained and demonstrated competency in medication administration. R5 's medication administration record (MAR) for December 2022, indicated ULP-H had administered R5's morning medications on December 1, 2022. ULP-I ULP-I was hired on October 7, 2022, to provide direct care services under the licensee's assisted living with dementia care license. ULP-I training record lacked evidence ULP-I had been training and demonstrated competency in medication administration. R1's medication administration record (MAR) for November 2022, indicated ULP-I administered R1's medications on November 1, 2, 4, 6, 9, 19, 20, 21, and 29. 2022. On December 6, 2022, at 11:55 a.m., community coordinator (CC)-A stated she was unable to find documentation for ULP-G and ULP-I pertaining to the training and competencies by a registered nurse for medication administration. The licensee's Delegation of Assisted Living Services policy dated August 1, 2021, indicated: The registered nurse or other health professional may delegate procedures according to the following: -The registered nurse instructed the home health aide in the proper methods to perform the procedure with respect to each client. -The home health aide demonstrated to the registered nurse competence in the procedure. -The home health aide's competence is	01750		

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01750	Continued From page 77 documented in his/her personnel file. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate On December 7, 2022, at approximately 11:00 a.m., the surveyor exited the facility. As of the time of exit, immediacy remained in effect for immediate correction order 1750.	01750		
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 as prescribed for one of two residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	01760		

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01760	Continued From page 78 resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's diagnoses included: arterial fibrillation, chronic kidney disease, and Alzheimer's disease. R1's service plan dated August 2, 2021, indicated the resident received services which included medication administration. R1's prescriber's orders dated June 30, 2022, included acetaminophen PM 250/12.5 mg (milligrams) daily, Donepezil 5 mg daily, Famotidine 10 mg daily, gabapentin 100 mg, daily and oxybutynin 15 mg daily. R1's December 2022 medication administration record (MAR) lacked documentation to indicated R1 received the following medications: -On December 1, 2022, at 8:00 p.m., acetaminophen PM (pain and sleep) 250/12.5 mg; -On December 1, 2022, at 8:00 p.m., Famotidine (anti acid)10 mg; -On December 1, 2022, at 8:00 p.m., gabapentin (pain) 100 mg; -On December 1, 2022, at 8:00 p.m., oxybutynin (pain) 15 mg; and -On December 1, 3, and 4, 2022, at 8:00 p.m., Donepezil (medication to treat Alzheimer's disease) 5 mg. On December 6, 2022, at 2:00 p.m., community coordinator (CC)-A confirmed R1's December	01760		

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01760	Continued From page 79 2022 MAR indicated R1 did not receive the medications as indicated above. The licensee's Medication Documentation Procedure (undated) indicated each medication administered by staff will be documented in the client's clinical record. Documentation will be complete, accurate and legible, No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01790 SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and	01790		

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01790	Continued From page 80 (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure three of	01790		

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01790	Continued From page 81 three employees (unlicensed personnel (ULP)-G, ULP-H, ULP-I) were trained and had demonstrated competency to prepare and give medications for residents having unplanned time away. This had the potential to affect all seven (7) residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on December 5, 2022, at 9:30 a.m., community coordinator (CC)-A stated the licensee provided medication management services to seven (7) residents and the ULP would prepare and send medications with the residents for unplanned times away. ULP-G ULP-G was hired on September 8, 2022, to provide direct care services under the licensee's assisted living with dementia care license. On December 6, 2022, at 7:10 a.m., the surveyor observed ULP-G to prepare R 5's morning medications and administer to R5. Medications prepared by ULP-G included: - Docusate 100 mg (milligrams); and - Quetiapine 25 mg. ULP-H ULP-H was hired on May 24, 2022, to provide direct care services under the licensee's assisted	01790		

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01790	Continued From page 82 living with dementia care license. R5 's medication administration record (MAR) for December 2022, indicated ULP-H had administered R5's morning medications on December 1, 2022. ULP-I ULP-I was hired on October 7, 2022, to provide direct care services under the licensee's assisted living with dementia care license. R1's medication administration record (MAR) for November 2022, indicated ULP-I administered R1's medications on November 1, 2, 4, 6, 9, 19, 20, 21, and 29. 2022. ULP-G, ULP-H, and ULP-I's employee records lacked evidence to indicate they had been trained and demonstrated competency to prepare and provide medications to residents for unplanned times away from home. On December 6, 2022, at 2:00 p.m., CC-A stated ULP-G, ULP-H and ULP-I had not been trained and demonstrated competency to prepare and provide medications to residents for unplanned times away from home. The licensee's Protocol for Medications Away from Home (undated) indicated for unplanned time away (<24-hour business day notice) ULP can set up meds. The protocol does not address the training and competency of the ULP pertaining to the setting up of resident medications for unplanned time away from home. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	01790		

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01790	Continued From page 83 days	01790		
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document in the resident's record the disposition of the medications as required for one of one resident (R1) upon discharge. 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	01910		

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01910	Continued From page 84 was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R3 was admitted for services on April 26, 2022 and was discharged on September 6, 2022. R3's diagnoses include COPD (chronic obstructive pulmonary disease), peripheral arterial disease (abnormal narrowing of arteries other than those leading to the heart and or brain), emphysema (breathing disorder) and chronic respiratory failure. R3's service plan dated April 26, 2022, indicated R3 received medication management services which included medication administration. R3's discharge summary indicated R3 expired in the facility on September 6, 2022. R3's December 2022, Medication Administration Record (MAR) indicated R3 received the following scheduled medications: -levothyroxine (treat hypothyroidism) 100 mcg (micrograms); -melatonin (sleep) 3 mg (milligrams); -Quetiapine (anti psychotic) 25 mg; -MAPAP Arthritis ER (mild pain reliever) 650 mg; -Alprazolam (anti anxiety) 0.25 mg; -senna (laxative) 8.6 mg; and -Methadone (pain relief) 5 mg 1/2 tablet. R3's prescriber orders dated July 21, 2022, included all the above noted medications. R3's record lacked documentation of the	01910		

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01910	Continued From page 85 disposition of medications at the time of discharge. On December 6, 2022, at 2:00 p.m. community coordinator (CC)-A stated she was unable to find documentation pertaining to the disposition of R3 medications at the time of discharge. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
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 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 available record review and interview, the licensee provided a hazard vulnerability assessment or safety risk assessment of the physical environment on and around the property for the facility but the plan did not include mitigation factors. This deficient practice had the ability to affect all staff, residents, and visitors.	02040		

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02040	Continued From page 86 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: A record review and interview were conducted December 5, 2022, at approximately 12:15 p.m. with Community Coordinator (CC)-A on the hazard vulnerability assessment for the physical environment of the facility. Record review of the available documentation indicated that the licensee had not performed a hazard vulnerability assessment with mitigation factors on and around the property. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	02040		
02070 SS=I	144G.81 Subd. 4 Awake staff requirement An assisted living facility with dementia care providing services in a secured dementia care unit must have an awake person who is physically present in the secured dementia care unit 24 hours per day, seven days per week, who is responsible for responding to the requests of residents for assistance with health and safety needs, and who meets the requirements of section 144G.41, subdivision 1, clause (12). This MN Requirement is not met as evidenced by:	02070		

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02070	Continued From page 87 Based on observation, interview, and record review, the licensee failed to ensure one or more persons were physically present and available 24 hours a day, seven days a week, who were responsible for responding to requests for assistance with health and safety needs of residents in secured dementia care unit. This had the potential to affect all residents residing in the facility. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). This practice resulted in an immediate order on December 6, 2022, at 8:00 a.m. The findings include: The licensee failed to ensure one or more staff were always available during all shifts in the secured memory care unit. The licensee held an Assisted Living with Dementia Care license with a bed capacity of 14 residents and had a current census of 7 residents. During the entrance conference on December 5, 2022, at 9:30 a.m., community coordinator (CC)-A stated the facilities staffing schedule included one unlicensed personnel (ULP) (7:00 a.m. to 3:00 p.m.), one cook, and one community coordinator on the day shift; one ULP on the	02070		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30495	A. BUILDING: _____ B. WING _____	12/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCANDIA CAPITAL PARTNERS LLC	102 NORTH 58TH AVENUE WEST DULUTH, MN 55807

(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
02070	Continued From page 88 evening shift (3:00 p.m. to 11:00 p.m.); and one ULP on the night shift (11:00 p.m. to 7:00 a.m.). On December 5, 2022, at 9:30 a.m., CC-A stated there are times when there is only one staff person in the building, and they have had to leave the building unattended to assist the staff in the building across the street get a resident up off the floor after they have fallen. On December 5, 2022, at 3:00 p.m., ULP-F stated she has not had to leave the building unattended on her shift. She waits and takes the garbage out when the night shift arrived. ULP--F stated she is aware that other ULP have had to leave the building to assist staff at the building across the street. On December 6, 2022, at 6:35 a.m., ULP-G stated he knows that he is not supposed to leave the building unattended, but he has had to leave the building unattended to go across the street to assist their staff in getting a resident up off the floor. ULP-G stated he cannot remember the exact date. ULP-G stated he has work for the facility for about 90 days. On December 6, 2022, at 8:00 a.m., the surveyor reviewed the staffing schedule for December 2022, that was posted on the cupboard door in the office, and one ULP was scheduled for all days for December 2022. On December 5, 2022, at 2:27 p.m., regional director/licensed practical (RD/LPN)-D stated staff are not to leave the building unattended. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	02070		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30495	A. BUILDING: _____ B. WING _____	12/07/2022

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02070	Continued From page 89 On December 7, 2022, at approximately 11:00 a.m., the surveyor exited the facility. As of the time of exit, immediacy remained in effect for immediate correction order 2070.	02070		
02110 SS=F	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and	02110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30495	A. BUILDING: _____ B. WING _____	12/07/2022

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02110	Continued From page 90 (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure policies and procedures required in the licensing of assisted living facilities with dementia care were developed or implemented, and provided to each resident and/or the residents legal and designated representative at the time of move-in. This had the potential to affect all dementia care residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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: The licensee renewed their Assisted Living with Dementia Care license on August 1, 2022. On December 5, 2022, at 9:30 a.m., the surveyor asked community director (CC)-A for the licensee's Dementia Policies. CC-A provided the surveyor the policy book. CC-A stated they might be in the policy book. The policy book provided did not include the	02110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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02110	Continued From page 91 follow policies: -philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; -evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; -wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; -medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; -staff training specific to dementia care; -description of life enrichment programs and how activities are implemented; -description of family support programs and efforts to keep the family engaged; -limiting the use of public address and intercom systems for emergencies and evacuation drills only; -transportation coordination and assistance to and from outside medical appointments; and -safekeeping of residents' possessions. On December 5, 2022, at 2:27 p.m., the surveyor requested information pertaining to the licensee's Dementia Policies from regional director/licensed practical nurse (RD/LPN)-D. As of December 7, 2022, at 11:00 a.m., RD/LPN-D had not provided any information pertaining to the licensee's Dementia Polices. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02110		

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02170 SS=E	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following: (1) past and current interests; (2) current abilities and skills; (3) emotional and social needs and patterns; (4) physical abilities and limitations; (5) adaptations necessary for the resident to participate; and (6) identification of activities for behavioral interventions. (c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs. (d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to: (1) occupation or chore related tasks; (2) scheduled and planned events such as entertainment or outings; (3) spontaneous activities for enjoyment or those that may help defuse a behavior; (4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music; (5) spiritual, creative, and intellectual activities; (6) sensory stimulation activities; (7) physical activities that enhance or maintain a resident's ability to ambulate or move; and (8) outdoor activities. This MN Requirement is not met as evidenced	02170		

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02170	Continued From page 93 by: Based on interview and record review, the licensee failed to have a comprehensive evaluation for an activity plan for two of two residents (R1, R2) who received services under an assisted living with dementia care license. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: The licensee renewed their license as an Assisted Living with Dementia Care facility on August 1, 2022. R1 R1 diagnoses included Alzheimer's disease, atrial fibrillation, and chronic kidney failure. R1's record lacked evidence an individual activity assessment was completed that included the following: - past and current interests; - current abilities and skill' - emotional and social needs and patterns; - physical abilities and limitations; - adaptations necessary for the resident to participate; and - identification of activities for behavioral interventions.	02170		

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02170	Continued From page 94 R1's record lacked an individualized activity plan based on their activity evaluation. R2 R2's diagnoses include Alzheimer's disease. R2's record lacked evidence an individual activity assessment was completed that included the following: - past and current interests; - current abilities and skill' - emotional and social needs and patterns; - physical abilities and limitations; - adaptations necessary for the resident to participate; and - identification of activities for behavioral interventions. R2's record lacked an individualized activity plan based on their activity evaluation. On December 5, 2022, at 2:27 p.m., the surveyor requested information pertaining to R1 and R2's activity assessment and individualized activity plan from regional director/licensed practical nurse (RD/LPN)-D. As of December 7, 2022, at 11:00 a.m. RD/LPN-D had not provided any information pertaining to R1 and R2's assessments. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02170		
02410 SS=E	144G.91 Subd. 13 Personal and treatment privacy (a) Residents have the right to consideration of	02410		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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02410	Continued From page 95 their privacy, individuality, and cultural identity as related to their social, religious, and psychological well-being. Staff must respect the privacy of a resident's space by knocking on the door and seeking consent before entering, except in an emergency or where clearly inadvisable or unless otherwise documented in the resident's service plan. (b) Residents have the right to have and use a lockable door to the resident's unit. The facility shall provide locks on the resident's unit. Only a staff member with a specific need to enter the unit shall have keys. This right may be restricted in certain circumstances if necessary for a resident's health and safety and documented in the resident's service plan. (c) Residents have the right to respect and privacy regarding the resident's service plan. Case discussion, consultation, examination, and treatment are confidential and must be conducted discreetly. Privacy must be respected during toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure privacy was maintained during resident COVID-19 screening, weights, and blood pressure monitoring for two of five residents (R5, 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 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	02410		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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02410	Continued From page 96 of the residents). The findings include: On December 6, 2022, at 6:55 a.m., the surveyor observed unlicensed personnel (ULP)-G perform blood pressure monitoring, oxygen saturation monitoring, and weights on R5 in the dining room, with other residents present. On December 6, 2022, at 7:20 a.m., the surveyor observed ULP-H performed COVID-19 screening for R1's at the dining room table, with other residents present. On December 6, 2022, at 2:00 p.m., community coordinator (CC)-A stated staff should have provided the above care in the residents rooms. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02410		

MDH

11 E Superior Street
Duluth
218-302-6166

Type: Full
Date: *12/05/22*
Time: 10:30:28
Report: 7980221136

Food and Beverage Establishment Inspection Report

Location:
Scandia Capital Partners LLC
102 North 58th Avenue West
Duluth, MN55807
St. Louis County, 69

Establishment Info:
ID #: 0021868
Risk: Low
Announced Inspection: No

License Categories:

Expires on: / /

Operator:
Scandia Capital Partners LLC

Phone #: 2186282705
ID #: 27352

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

The following orders were issued during this inspection.

3-500B Microbial Control: hot and cold holding

3-501.16A2 ***** Priority 1 *****

MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.

BACK ROOM AMANA REFRIGERATOR WAS 42F MILK, CREAM CHEESE, 43F ORANGES. THERMOMETER WAS 42F. UNIT TURNED COLDER MAKE SURE DOOR IS TIGHTLY CLOSED. IF UNIT CAN NOT MAINTAIN TEMP IT MUST BE REPLACED

Comply By: 12/05/22

4-700 Sanitizing Equipment and Utensils

4-703.11B ***** Priority 1 *****

MN Rule 4626.0905B Sanitize food contact surfaces of equipment and utensils after cleaning by using mechanical hot water operations that achieve a utensil surface temperature of 160 degrees F (71 degrees C) and are set up and maintained in accordance with the specifications of NSF International and the manufacturer's data plate.

A THERMO LABEL WAS LEFT BUT STAFF DID NOT TEXT/EMAIL RESULTS. DISH MACHINE SANITIZING CAN NOT BE VERIFIED AT THIS TIME

Comply By: 12/05/22

4-300 Equipment Numbers and Capacities

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

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

STAFF DID NOT HAVE THERMO LABELS TO TEST DISH MACHINE

Comply By: 12/05/22

4-500 Equipment Maintenance and Operation

4-502.11B ***** Priority 2 *****

MN Rule 4626.0820B Calibrate food temperature measuring devices in accordance with manufacturer's specifications as often as necessary to ensure accuracy.

STAFF WAS UNAWARE ON HOW TO CALIBRATE THE THERMOMETER. STATED IT HAS NEVER BEEN CALIBRATED TO HER KNOWLEDGE

Comply By: 12/05/22

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.

BARB TOK THE FOOD SAFETY COURSE BUT HER CERTIFICATE IS FROM 2018 SHE WILL NEED TO RETAKE THE FULL 8 HOUR COURSE AND TEST THEN APPLY WITH MDH FOR HER CFPM CERTIFICATE. INFORMATION IS ON OUR WEBSITE ON PROCESS

Comply By: 12/05/22

Surface and Equipment Sanitizers

Quaternary Ammonia: = 400 PPM at Degrees Fahrenheit
Location: Lysol wipes
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Hot Holding
Temperature: 155 Degrees Fahrenheit - Location: Chicken and vegetables
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 40 Degrees Fahrenheit - Location: Samsung-sour cream
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 40 Degrees Fahrenheit - Location: Apple sauce
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 41 Degrees Fahrenheit - Location: Pork chops
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 42 Degrees Fahrenheit - Location: Amana-milk
Violation Issued: Yes

Process/Item: Upright Cooler
Temperature: 42 Degrees Fahrenheit - Location: Cream cheese
Violation Issued: Yes

Type: Full
Date: *12/05/22*
Time: 10:30:28
Report: 7980221136
Scandia Capital Partners LLC

Food and Beverage Establishment Inspection Report

Process/Item: Upright Cooler
Temperature: 43 Degrees Fahrenheit - Location: Oranges
Violation Issued: Yes

Process/Item: Upright Freezer
Temperature: Degrees Fahrenheit - Location: All freezers frozen hard
Violation Issued: No

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

Notes
1. Facility cooks and serves meals day of domestic equipment is allowed. If refrigerators can not maintain food at 41F or below they must be replaced.
2. Hand washing sign posted at hand sink
3. Choking poster posted in kitchen
4. Thin probe thermometer provided
5. Liquid pasteurized eggs used for breakfast, shell eggs are used for baking.
6. Illness policy discussed any food service employee with vomiting and/or diarrhea is excluded for 24 hours after symptoms stop. Illness is recorded in the log.

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

I acknowledge receipt of the MDH inspection report number 7980221136 of 12/05/22.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /

Inspection report reviewed with person in charge and emailed.

Signed:_____
Barb Buffalo
Cook

Signed: Sara Bents
Sara Bents
Environmental Health Specialist
Duluth
218-302-6184
sara.bents@state.mn.us

Report #: 7980221136

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

MDH

11 E Superior Street
Duluth

No. of RF/PHI Categories Out	3	Date	12/05/22
No. of Repeat RF/PHI Categories Out	0	Time In	10:30:28
Legal Authority MN Rules Chapter 4626		Time Out	

	Address	City/State	Zip Code	Telephone
Scandia Capital Partners LLC	102 North 58th Avenue West	Duluth, MN	55807	2186282705

License/Permit #	Permit Holder	Purpose of Inspection	Est Type	Risk Category
0021868	Scandia Capital Partners LLC	Full		L

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item — Mark "X" in appropriate box for COS and/or R

IN= in compliance **OUT=** not in compliance **N/O=** not observed **N/A=** not applicable **COS=** corrected on-site during inspection **R=** repeat violation

Compliance Status		COS	R
Supervision			
1 (IN) OUT	PIC knowledgeable; duties & oversight		
2 IN (OUT) N/A	Certified food protection manager, duties		
Employee Health			
3 (IN) OUT	Mgmt/Staff;knowledge,responsibilities&reporting		
4 (IN) OUT	Proper use of reporting, restriction & exclusion		
5 (IN) OUT	Procedures for responding to vomiting & diarrheal events		
Good Hygenic Practices			
6 (IN) OUT N/O	Proper eating, tasting, drinking, or tobacco use		
7 (IN) OUT N/O	No discharge from eyes, nose, & mouth		
Preventing Contamination by Hands			
8 (IN) OUT N/O	Hands clean & properly washed		
9 (IN) OUT N/A N/O	No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed		
10 (IN) OUT	Adequate handwashing sinks supplied/accessible		
Approved Source			
11 (IN) OUT	Food obtained from approved source		
12 IN OUT N/A (N/O)	Food received at proper temperature		
13 (IN) OUT	Food in good condition, safe, & unadulterated		
14 IN OUT (N/A) N/O	Required records available; shellstock tags, parasite destruction		
Protection from Contamination			
15 (IN) OUT N/A N/O	Food separated and protected		
16 IN (OUT) N/A	Food contact surfaces: cleaned & sanitized		
17 (IN) OUT	Proper disposition of returned, previously served, reconditioned, & unsafe food		

Compliance Status		COS	R
Time/Temperature Control for Safety			
18 (IN) OUT N/A N/O	Proper cooking time & temperature		
19 IN OUT (N/A) N/O	Proper reheating procedures for hot holding		
20 IN OUT (N/A) N/O	Proper cooling time & temperature		
21 (IN) OUT N/A N/O	Proper hot holding temperatures		
22 IN (OUT) N/A	Proper cold holding temperatures		
23 (IN) OUT N/A N/O	Proper date marking & disposition		
24 IN OUT (N/A) N/O	Time as a public health control: procedures & records		
Consumer Advisory			
25 IN OUT (N/A)	Consumer advisory provided for raw/undercooked food		
Highly Susceptible Populations			
26 (IN) OUT N/A	Pasteurized foods used; prohibited foods not offered		
Food and Color Additives and Toxic Substances			
27 IN OUT (N/A)	Food additives: approved & properly used		
28 (IN) OUT	Toxic substances properly identified, stored, & used		
Conformance with Approved Procedures			
29 IN OUT (N/A)	Compliance with variance/specialized process/HACCP		

Risk factors (RF) are improper practices or proceedures identified as the most prevalent contributing factors of foodborne illness or injury. **Public Health Interventions** (PHI) are control measures to prevent foodborne illness or injury.

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" in box if numbered item is **not** in compliance — Mark "X" in appropriate box for COS and/or R — **COS=** corrected on-site during inspection **R=** repeat violation

			COS	R
Safe Food and Water				
30	(IN) OUT N/A	Pasteurized eggs used where required		
31		Water & ice obtained from an approved source		
32	IN OUT (N/A)	Variance obtained for specialized processing methods		
Food Temperature Control				
33		Proper cooling methods used; adequate equipment for temperature control		
34	IN OUT (N/A) N/O	Plant food properly cooked for hot holding		
35	IN OUT N/A (N/O)	Approved thawing methods used		
36	X	Thermometers provided & accurate		
Food Identification				
37		Food properly labled; original container		
Prevention of Food Contamination				
38		Insects, rodents, & animals not present		
39		Contamination prevented during food prep, storage & display		
40		Personal cleanliness		
41		Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		

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Proper Use of Utensils				
43		In-use utensils: properly stored		
44		Utensils, equipment & linens: properly stored, dried, & handled		
45		Single-use/single service articles: properly stored & used		
46		Gloves used properly		
Utensil Equipment and Vending				
47		Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48	X	Warewashing facilities: installed, maintained, & used; test strips		
49		Non-food contact surfaces clean		
Physical Facilities				
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities: properly constructed, supplied, & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55		Physical facilities installed, maintained, & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing & plan review		

Food Recalls:

Person in Charge (Signature) **Date:** 12/07/22

Inspector (Signature) Sara Bents