Electronically Delivered

December 1, 2023

Licensee
Skyline Assisted Living
665 East 82nd Street
Bloomington, MN 55420

RE: Project Number(s) SL36345015

Dear Licensee:

On November 8, 2023, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the September 7, 2023, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

Jonathan Hill, Supervisor
State Evaluation Team
Email: jonathan.hill@state.mn.us
Telephone: 651-201-3993 Fax: 1-866-890-9290

PMB

Electronically Delivered

September 27, 2023

Licensee
Skyline Assisted Living
665 East 82nd Street
Bloomington, MN 55420

RE: Project Number(s) SL36345015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on September 7, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

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

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5), the MDH may impose fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment.
The MDH may impose 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 MDH 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 (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 survey:

St - 0 - 0495 - 144g.41 Subd. 1 (14) - Minimum Requirements - $3,000.00

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

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

The correction order documentation should include the following:

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

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

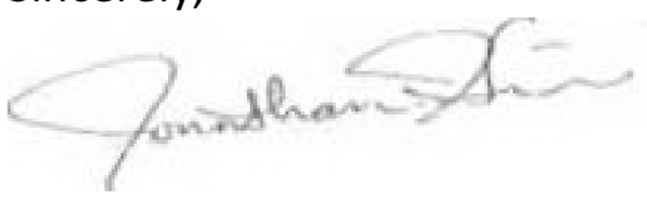
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for 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 state form with your organization's Governing Body.

If you have any questions, please contact me.

Sincerely,



Jonathan Hill, Supervisor
State Evaluation Team
Email: jonathan.hill@state.mn.us
Telephone: 651-201-3993 Fax: 651-281-9796

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36345	A. BUILDING: _____ B. WING _____	09/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYLINE ASSISTED LIVING	665 EAST 82ND STREET BLOOMINGTON, MN 55420

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL36345015-0 On September 5, 2023, through September 7, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were three (3) residents, all of whom received services under the Assisted Living with Dementia Care license. On September 5, 2023, at approximately 6:25 p.m. an immediate correction order was issued for tag 0495. On September 6, 2023, at 2:30 p.m. the immediacy of order 0495 was removed. The scope and level of noncompliance remained the same.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living licensed providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the 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.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated September 5, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	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	0 495		

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0 495	Continued From page 2 licensee failed to ensure staff and residents had access to a registered nurse (RN) on-call for current and foreseeable needs 24-hours a day, seven days per week, due to part time employment at a hospital. This had the potential to affect all residents and staff of the licensee. This resulted in an immediate order issued on September 5, 2023, at approximately 6:25 p.m. 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 September 5, 2023, at 11:00 a.m., during the entrance conference, the clinical nurse supervisor (CNS)-B stated they were the single registered nurse (RN) employed by the licensee. CNS-B further explained they were also employed at (Metro area) Hospital on an orthopedic unit six evenings each pay period (fourteen days). CNS-B stated they were "usually available by phone, but if they could not be reached, staff were expected to call 911 (emergency)." The licensed assisted living director/owner (LALD)- A stated the licensee did not use an outside agency for staffing and did not have another RN available when CNS-B was not available. LALD-A stated the licensee had been considering the idea of employing another RN who was able to cover when CNS-B was not available or working at another facility.	0 495		

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0 495	Continued From page 3 The current posted weekly staffing sheet dated August 31, 2023 through September 6, 2023, did not list a position for a CNS or RN. The posted Skyline Assisted Living Safety Information Sheet, undated, directed staff to "-in case of emergency, call 911 -if you fear for residents' safety and/or your own safety, call 911 then call [ULP-C's first name and cell phone number]. If [ULP-C] is not available, Call [LALD-A's first name and cell phone number]." On September 5, 2023, at 4:15 p.m., CNS-B stated they would expect residents to have access to a RN at all times either in person or phone or electronically. And stated their next shift at the hospital was scheduled for September 6, 2023, for the "evening shift." On September 5, 2023, at 4:35 p.m. unlicensed personnel (ULP)-E, stated if there was an emergency, they would first call 911, then "housing manager" [ULP-C] and lastly RN [CNS-B]. ULP-E stated, "about three weeks ago, during dinner" R1 had a "low blood sugar reading" and they could not reach CNS-B or ULP-C. ULP-E stated they used their "own judgment" and gave R1 orange juice, because administrative staff was not available to direct the emergency care for R1. ULP-E stated similar situations have happened "occasionally" in the past. ULP-E stated they were employed full time from 3:00 -10:00 p.m. On September 5, 2023, at 5:42 p.m. CNS-B stated the hospital shift was from 3:30 p.m. to 11:30 p.m.	0 495		

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0 495	Continued From page 4 The Licensee's Emergency Contacts for Staff policy dated June 2021, indicated all staff working at Skyline Assisted Living would be aware of who should be called in the event of an emergency. -Medical Emergencies: contact 911. and/or Clinical Nurse Supervisor and/or the Assisted living Director. The licensee's current Uniform Disclosure of Assisted Living Services and Amenities (UDALSA) did not give the option to not always have an RN available, however this section was not addressed and left blank. The Availability of an RN for Staff policy dated June 2021, indicated Skyline Assisted Living had: -RN available for consultation by staff performing delegated tasks -an appropriate licensed professional was available if performing other delegated services -RN would be readily available either in person, by telephone, or by other means to staff, at all times when the staff was providing services CNS-B's Skyline Assisted Living Position Description: Registered Nurse sheet signed February 22, 2023, did not address RN availability, when to call RN, direction if RN was not available, or parameters when to call 911. R1's service plan dated July 19, 2023, directed staff to: -check blood glucose daily before meals -notify RN if: If Blood Glucose is less than 70 or greater than 300 -notify the nurse for a blood sugar less than 70 or great than 300 The service plan further directed to provide "patient" with orange juice glucose less than 70 and to recheck glucose in "20 minutes."	0 495		

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0 495	Continued From page 5 On September 5, 2023, at 5:10 p.m., ULP-C stated he was not aware of the significance of a back-up for an RN who was employed at another facility, especially a hospital. ULP-C stated, "this was a wake-up call for us" and in the future would have a system in place for all residents and staff to always have RN access for the safety and well-being of the residents. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE On September 6, 2023, at 2:30 p.m. the immediacy of order 0495 was removed. The scope and level of noncompliance remained the same.	0 495		
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	0 680		

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0 680	Continued From page 6 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 preparedness plan with all the required content. This had the potential to affect the three residents receiving services under the assisted living license, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 September 5, 20223, at 11:00 a.m., a request was made to view the licensee's emergency preparedness plan. On September 6, 2023, at 1:00 p.m., unlicensed personnel (ULP-C) who was also the licensee's house manager, provided a Home Care manual for the emergency preparedness program (EPP), dated 2017. ULP-C stated this was the only information the licensee had. ULP-C stated the EPP forms and policies were printed from an	0 680		

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0 680	Continued From page 7 agency the licensee hired and were not developed specifically for the facility. ULP-C stated, "we don't even have the training manual (EPP) for assisted living, (ALF.)" The licensee's plan lacked the following required content: -current, all-hazards approach facility assessment -description of the population served by licensee -process for emergency preparedness (EP) cooperation with state and local EP officials/organizations -subsistence needs for staff and residents during an emergency -procedure for tracking staff and residents -development of all policies/procedures, based on assessment, and additional policies for: -sheltering in place -handling medical documents -handling and use of volunteers -arrangement with other facilities (including sister 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) -annual EP testing requirements. - process for cooperation and collaboration with local, tribal, regional, State and Federal EP to maintain integrated response. - process for arrangements with other facilities/providers to receive residents in the event of limitation/cessation of operations to maintain the continuity of services to residents. - policies and procedures on volunteers. On September 6, 2023, at 1:25 p.m. per telephone conversation the licensed assisted	0 680		

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0 680	Continued From page 8 living director (LALD-A) stated the licensee's current EPP lacked all required content. LALD-A further explained the licensee did not develop a disaster program to apply specifically to the facility and in addition, an evacuation plan, education/training, and drills were not completed. LALD-A stated, "This was a wake-up call. I think we just forgot about it. We will get it fixed." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code,	0 780		

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0 780	Continued From page 9 except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that are interconnected so that the actuation of one alarm causes all alarms in the dwelling unit to actuate. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On September 7, 2023, at approximately 10:00 a.m., survey staff toured the facility with the Housing Manager (HM)-C. During the facility tour, it was observed that the sleeping rooms that were equipped with smoke alarms were not interconnected with the other smoke alarms in the dwelling unit, so the actuation of one alarm would cause all alarms to operate. This deficient condition was visually verified by HM-C accompanying the tour. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780		

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0 790	Continued From page 10	0 790		
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: Based on observation and interview, the licensee failed to maintain fire extinguishers in accordance with MN State Fire Code as required by MN Statute 144G.45 Subd.2 (a)(2). This had the potential to affect all current 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). Findings include: On September 7, 2023, at approximately 10:00 a.m., survey staff toured the facility with the	0 790		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36345	A. BUILDING: _____ B. WING _____	09/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYLINE ASSISTED LIVING	665 EAST 82ND STREET BLOOMINGTON, MN 55420

(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
0 790	Continued From page 11 Housing Manager (HM)-C. During the facility tour, survey staff observed that portable fire extinguishers were not provided with tags or labels from certified service personnel indicating that annual maintenance had been performed. This deficient condition was visually verified by HM-C accompanying the tour. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 790		
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	0 810		

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0 810	Continued From page 12 least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop a fire safety and evacuation plan with the required elements; failed to provide a maintained fire safety and evacuation plan that showed the location and number of resident rooms; failed to provide a maintained fire safety and evacuation plan that contains employee actions to be taken in the event of a fire or similar emergency; fire protection procedures necessary for residents, and procedures necessary for resident movement, evacuation, or relocation during a fire or similar emergency with identification of unique or unusual resident needs for the movement or evacuation; failed to provide required employee training on fire safety and evacuation and failed to conduct required evacuation drills. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	0 810		

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0 810	Continued From page 13 Findings include: An interview and record review of the available documentation were conducted on September 7, 2023, at approximately 10:00 a.m. with the Housing Manager (HM)-C on the fire safety and evacuation plan, fire safety and evacuation training for the facility, and fire safety and evacuation drills for the facility. Record review of the available documentation indicated that the fire safety and evacuation plan was not maintained. The licensee had a copy of the Emergency Preparedness Manual. However, the policy was a basic policy resource book from a third-party provider and had not been edited or updated to fit the facility. Review of the available documentation provided by HM-C contained the following discrepancies. - The policy states that all residents are behind closed doors in a safe smoke compartment when the fire alarm goes off, and the facility has a shelter-in-place policy. During the tour, it was observed that the resident's bedroom door did not have fire-rated protection, and the facility did not have any smoke compartments or smoke compartment doors to contain fire and smoke. - The policy states that residents should be evacuated to the safest exit or nearest set of smoke compartment doors away from fire and smoke. This facility is a residential home and does not contain any sort of smoke compartments or smoke compartment doors to contain fire and smoke. - The policy states that when the fire alarm is triggered, all fire doors on magnetic holders will automatically close to contain smoke and fire and that residents are to remain behind these doors. The facility does not have any doors that are on	0 810		

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0 810	Continued From page 14 magnetic door holders or that are rated for smoke and fire. The facility also does not have a fire alarm system that supports the use of magnetic door holders. - The policy states that the system was wired directly to the fire station. The facility did not have a fire alarm system that supported the direct connection to the fire station. During the interview, HM-C stated that he thought the Licensed Assisted Living Director (LALD)-A modified the manual with the facility-specific information, but LALD-A could not find the manual book. LALD-A was not present at the time of the survey. HM-C verified that the fire safety and evacuation plan for the facility lacked these provisions. On the facility tour with the HM-C, it was observed that the posted fire safety and evacuation plan did not have the number of resident rooms. Record review of the Emergency Preparedness Manual provided by HM-C indicated that the plan did not have provisions for employee actions to be taken in the event of a fire or similar emergency, provisions for actions to be taken for residents who are capable of self-evacuation, and 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. During the interview, HM-C stated that the licensee did not have a policy or a fire safety and evacuation plan that included these items. Record review of the available documentation indicated that the licensee did not have fire protection procedures necessary for residents	0 810		

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0 810	Continued From page 15 included in the fire safety and evacuation plan. During the interview, HM-C indicated the fire safety and evacuation plan lacked fire protection procedures for the resident. Review of the Emergency Preparedness Manual provided by HM-C indicated that all staff receives emergency and disaster training in orientation and annually, not twice per year after initial hire as required by statute. Records of staff training were requested, but no training records were provided. During the interview, HM-C stated that the licensee provided annual training to employees, but not twice per year after the initial hire on the fire safety and evacuation plan, as required by statute. Record review of the available documentation indicated that the licensee did not conduct evacuation drills twice per year per shift and every other month as required by statute. Provided documentation indicated that the drills were conducted on 1/13/23 at 3 p.m., 4/24/23 at 9:30 a.m., and 6/17/23 at 1:33 p.m. with no further drills being documented. Provided documentation indicated that the facility failed to provide two drills on the second shift. The facility had two 12-hour shifts. HM-C verified that there were no further documented drills for the facility and verified this deficient condition. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not	0 970		

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0 970	Continued From page 16 include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the facility's liability for health, safety, or personal property of a resident. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On September 5, 2023, at 11:00 a.m., a copy of the facility's assisted living contract was requested. The Licensee's current assisted living contract included a clause within PROVISIONS RELATED TO LIABILITY (section #24)which indicated the following: -Damage of Injury to Resident of Resident's Property. The licensee was not responsible for any damage or injury suffered by the resident, their property, their guests or their property that	0 970		

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0 970	Continued From page 17 was not caused by the licensee. The licensee strongly recommend that Resident obtained renter's insurance at an appropriate level to insure against loss of Resident's personal property, as well as related incidental and consequential damages, or such other or additional insurance as Resident considers necessary to protect against injuries and property damage. The licensee's insurance may not cover the loss of your personal property and the incidental and consequential damages arising from the loss of such property. Your personal property included but was not limited to dentures, glasses and hearing aids. -Acts of Third Parties. The licensee was not responsible for the actions of, or for any damages, injury or harm caused by the actions of, third parties (such as other residents, guests, intruders, or trespassers) who were not under our direct and actual control. -Resident's Responsibility for Damages. The licensee would not be responsible for (a) any loss, property damage (including plumbing problems) or cost of repairs or service caused by the resident's use of the Room or the Facility facilities, normal wear and tear excepted; (b) any loss or damage to the Room or the Facility facilities caused by doors or windows left open by the resident or their guests; (c) all costs or losses we incur because of abandonment of the Room or other violations of this Agreement the resident.. -Resident's Responsibility for Costs. The resident would be responsible for all costs the licensee incurred which were associated in any way with breach or violation of any of the provisions of this Agreement and with the enforcement of this Agreement, including but not	0 970		

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0 970	Continued From page 18 limited to costs associated with collection activities and eviction, whether by court action or otherwise, additional staff time, court costs, reasonable attorneys' fees (whether in connection with a court action or not). Such costs would be billed to the resident as additional rent and were subject to the late fees described in paragraph 7.A. of this Agreement. The resident would waive the facility's liability health, safety, or personal property of the resident. Page 13, section 18, noted, Personal Property: "resident agreed that Provider was not responsible for any loss or damage to Resident's personal property due to any reason or cause, including theft, other than Provider's own negligence. Resident further agrees that Provider is not responsible for damage to Resident's personal property due to fire, water, tornado or other acts of nature and events beyond Provider's control. On September 5, 2023, at 12:30 p.m., unlicensed personnel (ULP-C) who was also the licensee's house manager, stated they were unaware of the clauses which waved the liability the licensee's contained in the resident contract/agreement but "it made sense." ULP-C stated they would have current residents resign an updated resident agreement. On September 7, 2023, at 3:00 p.m., the licensed assisted living director (LALD-A) stated this was an oversight and would be corrected for all current and future residents of the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 970		

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01470	Continued From page 19	01470		
01470 SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this	01470		

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01470	Continued From page 20 subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide orientation to assisted living licensing requirements and regulations prior to providing services for two of two employees, clinical nurse supervisor (CNS-B) and unlicensed personnel (ULP-D). 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 September 5, 2023, 10:00 a.m., through September 6, 2023, at 2:00 p.m.,	01470		

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01470	Continued From page 21 - CNS-B was observed overseeing the daily care and services provided to residents of the facility - ULP-D was observed administering medication, providing activities of daily living, and preparing meals for residents (R1, R2, R3) CNS-B was hired on February 25, 2023, to provide supervision under the licensee's Assisted Living with Dementia Care license. ULP-D was hired on June 9, 2023, to provide direct care and services to residents of the facility. The employees lacked the required orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents to include: - Overview of Assisted Living statutes - Review of provider's policies and procedures - Handling emergencies and using emergency services - Reporting maltreatment of vulnerable adults - Assisted Living bill of rights - Handing of resident complaints, reporting of complaints, where to report - Consumer advocacy services - Review of types of Assisted Living services the employee will provide and provider's scope of license - Orientation to each specific resident and services provided - Dementia training required for all direct care staff and supervisors - Initial eight hours of dementia care training within 160 hours. On September 6, 2023, at 11:15 a.m., unlicensed personnel (ULP-C) who was also the licensee's house manager, stated they trained and provided orientation to CNS-B, and CNS-B trained/orientation to ULP-D.	01470		

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01470	Continued From page 22 On September 6, 2023, at 12:00 p.m., EduCare (agency which provided training programs and documentation tools that increased staff knowledge and skills while demonstrating competency to comply with state and federal regulatory requirements.) manager of training and customer services (EM-F) stated, via telephone, an orientation transcript of completion was not in either employee's (CNS-B and ULP-D) education record. EM-F stated the first record in CNS-B's and ULP-Ds were both dated, June 2023. for dementia training only. On September 6, 2023, at 1:10 p.m., the licensed assisted living director (LALD-A) stated there was an "error on our side." LALD-A explained they thought all education would be auto-populated by EduCare. LALD-A stated the licensee was not contacted by EduCare and therefore none of the current employees were orientated to the new licensure as of August 2021 for assisted living facilities. On September 6, 2023, at 1:45 p.m., ULP-C stated they were not aware of the required orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. ULP-C stated he was confused with the licensee's new-hire orientation and "did not even know about it (the required orientation to assisted living facility licensing requirements and regulations) until it was brought up yesterday." The licensee lacked policies to include the new Assisted Living Licensure requirements, that went into effect August 1, 2021. No further information provided.	01470		

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01470	Continued From page 23 TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	01470		

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

Type: Full
Date: *09/05/23*
Time: 14:15:29
Report: 1004231134

Food and Beverage Establishment Inspection Report

Location:
Skyline Assisted Living
665 East 82nd Street
Bloomington, MN55420
Hennepin County, 27

Establishment Info:
ID #: 0039102
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6127032857
ID #:

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

The following orders were issued during this inspection.

2-200 Employee Health

2-201.11C ***** Priority 1 *****

MN Rule 4626.0040C The person in charge must record all reports of diarrhea or vomiting made by food employees and report those illnesses to the regulatory authority at the specific request of the regulatory authority.

NO EMPLOYEE ILLNESS LOG USED BY ESTABLISHMENT. ENSURE ALL EMPLOYEE REPORTS OF DIARRHEA, VOMITING, OR OTHER GASTROINTESTINAL SYMPTOMS OR ILLNESS THAT COULD BE SPREAD THROUGH FOOD ARE RECORDED INCLUDING ALL DATES OF ILLNESS.

Comply By: 09/05/23

3-300B Protection from Contamination: cross-contamination, eggs

3-302.11A(1) ***** Priority 1 *****

MN Rule 4626.0235A(1) Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.

RAW SHELL EGGS FOUND STORED OVER CHEESE AND OTHER READY-TO-EAT ITEMS. ENSURE RAW ANIMAL FOODS, INCLUDING EGGS, ARE STORED BELOW READY-TO-EAT ITEMS.

Comply By: 09/05/23

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.

THERMOLABELS LEFT ON SITE INDICATED THE MACHINE WAS NOT REACHING A

SURFACE SANITIZING TEMPERATURE OF 160*F. ENSURE UTENSIL SURFACE TEMPERATURE REACHES A MINIMUM OF 160*F FOR SANITIZING.

Comply By: 09/05/23

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.

NO IRREVERSIBLE TEMPERATURE INDICATOR FOR USE WITH THE HIGH TEMPERATURE SANITIZING DISH MACHINE. PROVIDE AND USE FREQUENTLY TO ENSURE A MINIMUM OF 160*F UTENSIL SURFACE TEMPERATURE IS REACHED FOR SANITIZING. *STICKER STRIPS LEFT ON SITE.

Comply By: 09/05/23

4-500 Equipment Maintenance and Operation

4-501.11AB

MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.

DISH MACHINE IS UNABLE TO REACH REQUIRED UTENSIL SURFACE TEMPERATURE FOR SANITIZING. HAVE UNIT SERVICED/ADJUSTED TO ENSURE A MINIMUM OF 160*F IS REACHED FOR SANITIZING.

Comply By: 09/05/23

Surface and Equipment Sanitizers

Utensil Surface Temp.: = at 150 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: Yes

Food and Equipment Temperatures

Process/Item: CHEESE
Temperature: 39 Degrees Fahrenheit - Location: KITCHEN REFRIGERATOR
Violation Issued: No

Process/Item: MILK
Temperature: 40 Degrees Fahrenheit - Location: KITCHEN REFRIGERATOR
Violation Issued: No

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

INSPECTION WAS CONDUCTED BY MOLLY DOUGHERTY (FPLS) IN CONJUNCTION WITH A HEALTH REGULATIONS DIVISION (HRD) SURVEY CONDUCTED BY MARY BRUESS.

DISCUSSED:
-EMPLOYEE ILLNESS POLICY AND LOG
-HANDWASHING
-SANITIZER USE AND TEST KITS
-CLEANING/SANITIZING FOOD CONTACT SURFACES AND UTENSILS

-HIGH TEMPERATURE SANITIZING DISH MACHINE TEMPERATURE VERIFICATION
-DATE MARKING PROCEDURES
-THERMOMETER USE AND CALIBRATION
-SERVING A HIGHLY SUSCEPTIBLE POPULATION (NO RAW/UNDERCOOKED ANIMAL FOODS, NO UNPASTEURIZED JUICE, MILK, ETC)
-VOMIT/FECAL INCIDENT CLEAN UP PROCEDURES
-FOOD SOURCE
-FOOD SERVICE PROCEDURES
-PEST CONTROL
-PHYSICAL FACILITIES AND MAINTENANCE

*REPORT WAS DISCUSSED WITH THE PERSON IN CHARGE, MOHAMED AND WITH THE NURSE EVALUATOR, MARY.

*FLOORS ARE LINOLEUM AND CEILING AND WALLS ARE PAINTED DRYWALL. COUNTERTOPS ARE LAMINATE AND CABINETS ARE PAINTED WOOD WITH HALLOW BASE. ALL ARE FOUND TO BE IN GOOD CONDITION AND WILL BE MONITORED AT FUTURE INSPECTIONS. IF AT SUCH A TIME THEY ARE FOUND TO BE A CONCERN OR RISK OF CONTAMINATION, THEY WILL BE ORDERED TO BE REPLACED AND BROUGHT UP TO CODE.

*KITCHEN HAS A 2-BASIN SINK. ONE BASIN IS DESIGNATED AS THE HANDWASHING SINK. THIS BASIN MAY ONLY BE USED FOR HANDWASHING PURPOSES.

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*IF ANY RESIDENT COMPLAINS OF ILLNESS, CONTACT THE MINNESOTA DEPARTMENT OF HEALTH AND PROVIDE THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER TO THE RESIDENT. THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER IS 1-877-366-3455.

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 1004231134 of 09/05/23.

Certified Food Protection Manager: TANIIM MOHAMED

Certification Number: FM110810 Expires: 12/13/24

Signed: _____

MOHAMED NUR
HOUSING MANAGER

Signed: Molly Dougherty

Molly Dougherty
Public Health Sanitarian
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