



*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically Delivered

September 20, 2024

Licensee

Minnesota Group Homes LLC  
10355 Grand Avenue South  
Bloomington, MN 55420

RE: Project Number(s) SL35663015

Dear Licensee:

On August 26, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the June 4, 2024, 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,

A handwritten signature in black ink, appearing to read 'Jess Schoenecker'.

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

JMD



*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically Delivered

July 5, 2024

Licensee

Minnesota Group Homes LLC  
10355 Grand Avenue South  
Bloomington, MN 55420

RE: Project Number(s) SL35663015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on June 4, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

### **STATE CORRECTION ORDERS**

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

### **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), MDH may impose fine amounts of either \$1,000 or \$5,000 to licensees who are found to be responsible for maltreatment. 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. 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 - 0820 - 144g.45 Subd. 2 (g) - Fire Protection And Physical Environment - \$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 MDH within 15 calendar days of the correction order receipt date.

To submit a reconsideration request, please visit:

**<https://forms.web.health.state.mn.us/form/HRDAppealsForm>**

#### **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. to submit a hearing request, please visit:

**<https://forms.web.health.state.mn.us/form/HRDAppealsForm>**

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. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **<https://forms.office.com/g/Bm5uQEPhVa>**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at [susan.winkelmann@state.mn.us](mailto:susan.winkelmann@state.mn.us) or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,

A handwritten signature in cursive script that reads "Kelly Thorson".

Kelly Thorson, Supervisor

State Evaluation Team

Email: [Kelly.Thorson@state.mn.us](mailto:Kelly.Thorson@state.mn.us)

Telephone: 320-223-7336 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>35663</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/04/2024</b>
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NAME OF PROVIDER OR SUPPLIER  <b>MINNESOTA GROUP HOMES LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>10355 GRAND AVENUE SOUTH BLOOMINGTON, MN 55420</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	<p><b>Initial Comments</b></p> <p>*****ATTENTION*****</p> <p><b>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S)</b></p> <p>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey.</p> <p>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.</p> <p><b>INITIAL COMMENTS:</b></p> <p><b>SL35663015</b></p> <p>On June 3, through June 5, 2024, the Minnesota Department of Health conducted an initial survey at the above provider, and the following correction orders are issued. At the time of the survey, there was one resident receiving services under the provider's Assisted Living license.</p> <p>An immediate correction order was identified on June 04, 2024, issued for SL35663015, tag identification 0820.</p> <p>On June 05, 2024, the immediacy of correction order 0820 was removed, however non-compliance remained at scope and level of H.</p>	0 000	<p>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.</p> <p><b>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.</b></p> <p><b>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.</b></p> <p>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.</p>	
0 470 SS=F	<b>144G.41 Subdivision 1 Minimum requirements</b>	0 470		

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

Minnesota Department of Health

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0 470	<p>Continued From page 1</p> <p>(11) develop and implement a staffing plan for determining its staffing level that:</p> <ul style="list-style-type: none"> <li>(i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility;</li> <li>(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</li> <li>(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;</li> </ul> <p>(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:</p> <ul style="list-style-type: none"> <li>(i) awake;</li> <li>(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;</li> <li>(iii) capable of communicating with residents;</li> <li>(iv) capable of providing or summoning the appropriate assistance; and</li> <li>(v) capable of following directions;</li> </ul> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a written staffing plan that included an evaluation completed by the clinical nurse supervisor (CNS) (as indicated in Minnesota Administrative Rule 4659.0180) at least twice a year. The licensee further failed to post the staffing schedule in a central location. This had the potential to affect all residents, staff, and</p>	0 470		

Minnesota Department of Health

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0 470	<p>Continued From page 2</p> <p>visitors.</p> <p>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 the residents).</p> <p>The findings include:</p> <p>The licensee held an assisted living license and was licensed for a capacity of four residents and had a current census of one resident.</p> <p>On June 3, 2024, at 11:00 a.m., the surveyor observed the common areas of the facility and noted the lack of a 24-hour staffing schedule. The facility also lacked a written staffing plan.</p> <p>On June 4, 2024, at 2:00 p.m., clinical nurse supervisor (CNS)-B and housing manager (HM)-A stated they were unaware a staffing schedule was required to be posted. HM-A stated they look at the daily needs of the resident and change the staffing whenever it is needed. He stated they do not document on the needs or changes.</p> <p>The licensee's untitled and undated policy referencing minimum requirements for facility indicated [the facility] shall develop a staffing plan to determine:</p> <ul style="list-style-type: none"> <li>- [the facility] has sufficient staffing at all times to accommodate foreseeable unscheduled needs of its residence</li> <li>- ensures that the facility can respond promptly to</li> </ul>	0 470		

Minnesota Department of Health

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0 470	Continued From page 3  emergencies of any type (resident, facility, weather, etc.)  No further information was provided.  TIME PERIOD FOR CORRECTION: Seven (7) 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: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and  This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated June 4, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer	0 480		

Minnesota Department of Health

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0 480	Continued From page 4 to the FBEIR for any compliance dates.	0 480		
0 550 SS=F	<p><b>144G.41 Subd. 7 Resident grievances; reporting maltreatment</b></p> <p>All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to post the required information related to the grievance procedure and contact information for the Office of Ombudsman for Long-Term Care and Mental Health and Developmental Disabilities. This had the potential to affect all the licensee's current residents, staff, and visitors.</p> <p>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</p>	0 550		

Minnesota Department of Health

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0 550	<p>Continued From page 5</p> <p>or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents).</p> <p>The findings include:</p> <p>The licensee lacked a posting of the grievance procedure, including the name, telephone number and e-mail contact information for the individuals who were responsible for handling resident grievances and contact information for the Office of Ombudsman for Long-Term Care and Mental Health and Developmental Disabilities.</p> <p>On June 3, 2024, during the facility tour at 11:00 a.m., the surveyor observed the entry area and common areas within the facility and noted there was no required posting of the grievance procedure or contact information for the Office of Ombudsman.</p> <p>On June 4, 2024, clinical nurse supervisor (CNS)-B and housing manager (HM)-A stated they were not aware of the required postings requirement.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-One (21) days</p>	0 550		
0 580 SS=F	<p>144G.42 Subd. 2 Quality management</p> <p>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</p>	0 580		

Minnesota Department of Health

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0 580	<p>Continued From page 6</p> <p>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.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to implement and maintain a quality management program appropriate to the size of the facility and relevant to the type of services provided. This had the potential to affect all current residents, staff, and visitors.</p> <p>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).</p> <p>The findings include:</p> <p>On June 3, 2024, at 2:00 p.m. housing manager (HM)-A and clinical nurse supervisor (CNS)-B stated they discussed infection control, but they did not document quality management meetings.</p> <p>The licensee's undated Quality Improvement policy indicated [the facility] has established a quality improvement program on the organization's size and appropriate to the type of services provided to assure that effective, comprehensive, and appropriate plans are</p>	0 580		

Minnesota Department of Health

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0 580	Continued From page 7  operational for all clients with the organization [the facility] shall engage in quality management plan relevant to the type of services [the facility] provides.  No further information provided.  TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 580		
0 650 SS=F	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		

Minnesota Department of Health

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0 650	<p>Continued From page 8</p> <p>Based on interview and record review, the licensee failed to ensure employee records contained the required content for one of one employee, (unlicensed personnel (ULP)-C).</p> <p>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).</p> <p>The findings include:</p> <p>ULP-C began employment on July 10, 2020, to provide direct care services to residents.</p> <p>ULP-C's employee record lacked the following: -documentation of a current annual performance review that identified areas of improvement needed and training needs.</p> <p>On June 5th, 2024, at 10:00 a.m., clinical nurse supervisor (CNS)-B stated a performance review had not been completed since date of hire. She stated she was aware that annual reviews are required and would use an annual performance review form for all employee reviews.</p> <p>The licensee's Personnel Records policy dated May 2, 2020, indicated [the facility] will have the following documents in the personnel record: performance reviews.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-One (21) days</p>	0 650		

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0 660 SS=F	<p><b>144G.42 Subd. 9 Tuberculosis prevention and control</b></p> <p>(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.</p> <p>(b) The facility must maintain written evidence of compliance with this subdivision.</p> <p>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), which included an updated TB risk assessment for the facility.</p> <p>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).</p> <p>The findings include:</p>	0 660		
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0 660	<p>Continued From page 10</p> <p>The facility's TB risk assessment was dated July 13, 2020.</p> <p>The facility did not review the TB risk assessment annually.</p> <p>The licensee's TB facility risk assessment dated July 13, 2020, indicated the TB risk assessment would be conducted or updated annually and/or following risk of exposure.</p> <p>On June 4, 2024, at 2:00 p.m. CNS-A stated she was not aware that the TB risk assessment needed to be completed annually.</p> <p>The Minnesota Department of Health guidelines Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July 2013, and based on CDC guidelines, indicated a TB infection control program should include an annual facility TB risk assessment. The guidelines also indicated an employee may begin working with patients (residents) after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW starts working with patients. Baseline TB screening should be documented in the employee's record.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p>	0 660		

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0 680	Continued From page 11	0 680		
0 680 SS=F	<p>144G.42 Subd. 10 Disaster planning and emergency preparedness</p> <p>(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.</p> <p>This MN Requirement is not met as evidenced by:                      Based on interview and record review, the licensee failed to have a written emergency preparedness plan with all the required content. This had the potential to impact all residents, staff, and visitors.</p> <p>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</p>	0 680		

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0 680	<p>Continued From page 12</p> <p>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).</p> <p>The findings include:</p> <p>On June 3, 2024, at 10:00 a.m., the surveyor reviewed the emergency preparedness binders and found they lacked the required information.</p> <p>On June 5, 2024, at 10:00 a.m., housing manager (HM)-A stated the emergency plan is missing parts and some of it is in one binder and another part in another binder and some is old and needs to be replaced.</p> <p>The licensee's Emergency Preparedness policy, dated May 2, 2020, indicated [the facility] will have an identified plan in place to assure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupts services.</p> <p>No additional information provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p>	0 680		
0 780 SS=F	<p>144G.45 Subd. 2 (a) (1) Fire protection and physical environment</p> <p>(a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and:</p> <p>(1) for dwellings or sleeping units, as defined in the State Fire Code:</p>	0 780		

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0 780	<p>Continued From page 13</p> <ul style="list-style-type: none"> <li>(i) provide smoke alarms in each room used for sleeping purposes;</li> <li>(ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms;</li> <li>(iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics;</li> <li>(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</li> <li>(v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated;</li> </ul> <p>This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide interconnected smoke alarms throughout the facility. This had the potential to directly affect all residents, staff, and visitors.</p> <p>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).</p> <p>Findings include:</p> <p>On a facility tour on June 4, 2024, at 12:10 p.m., with house manager (HM-A), it was observed that</p>	0 780		

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0 780	<p>Continued From page 14</p> <p>the smoke alarms located inside the resident sleeping rooms two, three, four, five, and outside in the immediate vicinity of sleeping rooms throughout the facility were not interconnected so activation of the alarms activates all alarms throughout the facility.</p> <p>Smoke alarms are required to be installed inside and outside in the immediate vicinity of all sleeping rooms. All smoke alarms are required to be interconnected so activation of one alarm activates all alarms throughout the facility.</p> <p>During the tour the smoke alarms were tested and HM-A, verified the smoke alarms were not interconnected so activation of one alarm activates all alarms throughout the facility. HM-A verified they understood the requirement and would have a new smoke alarm installed.</p> <p>TIME PERIOD FOR CORRECTION: Two (2) day.</p>	0 780		
0 800 SS=F	<p>144G.45 Subd. 2 (a) (4) Fire protection and physical environment</p> <p>(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.</p> <p>This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the facility's physical environment in a continuous state of good repair</p>	0 800		

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0 800	<p>Continued From page 15</p> <p>and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors.</p> <p>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).</p> <p>Findings include:</p> <p>On June 4, 2024, at 12:10 p.m., survey staff toured the facility with house manager (HM-A). The following was observed:</p> <p>It was observed that the exterior dryer vent at the rear of the facility was dirty and obstructed with lint. Obstructed dryer vents are a fire hazard and should be cleaned and maintained to allow proper function and venting.</p> <p>It was observed that the exterior concrete stoops at the front and side entry doors had an uneven surface from loose and broken concrete, and areas at the edge that were broken off. Exterior steps should have a solid, even surface so they do not create a tripping hazard.</p> <p>It was observed that the fire evacuation map posted on the main floor had room numbers that were not the same as the room numbers on the resident room doors. Resident rooms labeled on the doors as 1 and 3 were not in the location indicated on the evacuation diagram. HM-A stated they would update the map to show the</p>	0 800		

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0 800	Continued From page 16  correct room numbers and locations.  HM-A visually verified these deficient findings at the time of discovery.  TIME PERIOD FOR CORRECTION: Seven (7) days.	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment  (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one	0 810		

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0 810	<p>Continued From page 17</p> <p>evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required fire drills. This had the potential to directly affect all residents, staff, and visitors.</p> <p>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).</p> <p>The findings include:</p> <p>On June 4, 2024, at 1:35 p.m. house manager (HM-A) provided documentation on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility.</p> <p><b>FIRE SAFETY AND EVACUATION PLAN</b></p> <p>The licensee's FSEP, undated, failed to include the following:</p> <p>The FSEP did not include an evacuation map with a floor plan accurate to the building layout that showed the location and number of resident</p>	0 810		

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0 810	<p>Continued From page 18</p> <p>sleeping rooms.</p> <p>During an interview on June 4, 2024, at 1:50 p.m., HM-A stated that they would work on updating the evacuation maps and including one in the FSEP.</p> <p><b>DRILLS</b></p> <p>Record review indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month. HM-A was unable to provide documentation of any fire drills conducted at the facility.</p> <p>During an interview on June 4, 2024, at 1:50 p.m., HM-A stated they would email fire drill logs to survey staff for review. Survey staff reviewed fire drill logs that were emailed June 6, 2024. The logs show only 3 drills were conducted in 2023 and only 2 drills for 2024. The logs do not indicate which staff members or shift participated in the drills. The number of fire drills conducted does not meet the minimum requirement of at least one drill every other month. The logs do not confirm that each employee participated in at least two drills per year, or that at least two drills per shift were conducted. No further details were provided.</p> <p><b>TIME PERIOD FOR CORRECTION: Twenty-one (21) days.</b></p>	0 810		
0 820 SS=H	<p><b>144G.45 Subd. 2 (g) Fire protection and physical environment</b></p> <p>(g) Existing construction or elements, including assisted living facilities that were registered as</p>	0 820		

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0 820	<p>Continued From page 19</p> <p>housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction.</p> <p>This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide facilities that were not a distinct hazard to life. This had the potential to directly affect all of the residents and staff.</p> <p>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).</p> <p>Findings include:</p> <p>On a facility tour on June 4, 2024, at 12:10 p.m. with house manager (HM-A) it was observed that compliant emergency escape and rescue openings were not provided in resident sleeping rooms 2 and 3.</p> <p>Occupied Resident Rooms</p>	0 820		

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0 820	<p>Continued From page 20</p> <p>Resident sleeping room 2, located on the main floor, emergency escape and rescue clear window opening measurements are 31 inches wide, 18 inches in height and 558 square inches in openable area. The window was measured with HM-A, and survey staff present. The window did not meet the minimum requirements for clear opening height and openable area.</p> <p>Existing emergency escape and rescue openings are required to meet a minimum clear opening area of 648 square inches and have a minimum dimension of 20 inches in height and a minimum dimension of 20 inches in width. The windowsill height from the floor to the clear opening shall be not more than 48 inches.</p> <p>Unoccupied Resident Rooms</p> <p>Resident sleeping room 3, located on the main floor, emergency escape and rescue clear window opening measurements are 31 inches wide, 18 inches in height and 558 square inches in openable area. The window was measured with HM-A, and survey staff present. The window did not meet the minimum requirements for clear opening height and openable area.</p> <p>Existing emergency escape and rescue openings are required to meet a minimum clear opening area of 648 square inches and have a minimum dimension of 20 inches in height and a minimum dimension of 20 inches in width. The windowsill height from the floor to the clear opening shall be not more than 48 inches.</p> <p>It was explained to HM-A that at least one compliant emergency escape and rescue opening is required within each resident sleeping room.</p>	0 820		

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0 910 SS=C	<p><b>144G.50 Subd. 2 (a-b) Contract information</b></p> <p>(a) The contract must include in a conspicuous place and manner on the contract the legal name and the health facility identification of the facility.</p> <p>(b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of:</p> <p>(1) the facility and contracted service provider when applicable;</p> <p>(2) the licensee of the facility;</p> <p>(3) the managing agent of the facility, if applicable; and</p> <p>(4) the authorized agent for the facility.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for one of one resident (R1).</p> <p>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).</p> <p>The findings include:</p> <p>R1's Assisted Living Contract was signed by R1 October 23, 2023.</p> <p>R1's contract did not include: -health facility identification of the facility -authorized agent of facility</p>	0 910	<p>This immediate correction order identified on June 04, 2024, has had the immediacy lifted as of June 05, 2024, however non-compliance remained a scope and level of H.</p>	
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>35663</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/04/2024</b>
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NAME OF PROVIDER OR SUPPLIER  <b>MINNESOTA GROUP HOMES LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>10355 GRAND AVENUE SOUTH BLOOMINGTON, MN 55420</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 910	<p>Continued From page 22</p> <p>On June 6, 2024, at 10:00 a.m., housing manager (HM)-A stated he was not aware of the required information on the assisted living contract.</p> <p>The licensee's undated Assisted Living Contract Requirements policy indicated the facility contract shall contain the following information in its written contract to residents: - authorized agent for the facility</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-One (21) days</p>	0 910		
0 930 SS=C	<p>144G.50 Subd. 2 (d-e; 1-4) Contract information</p> <p>(d) The contract must include a description of the facility's complaint resolution process available to residents, including the name and contact information of the person representing the facility who is designated to handle and resolve complaints.</p> <p>(e) The contract must include a clear and conspicuous notice of: (1) the right under section 144G.54 to appeal the termination of an assisted living contract; (2) the facility's policy regarding transfer of residents within the facility, under what circumstances a transfer may occur, and the circumstances under which resident consent is required for a transfer; (3) contact information for the Office of Ombudsman for Long-Term Care, the Ombudsman for Mental Health and Developmental Disabilities, and the Office of Health Facility Complaints; (4) the resident's right to obtain services from an</p>	0 930		

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0 930	<p>Continued From page 23</p> <p>unaffiliated service provider;</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for one of one resident (R1).</p> <p>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).</p> <p>The findings include:</p> <p>R1's assisted living contract was signed by R1 October 23, 2023.</p> <p>R1's contract failed to include the following required content: - contact information for office of ombudsman for long term care, mental health and developmental disabilities and the office of health facility complaints</p> <p>On June 5, 2024, at 11:00 a.m., housing manager (HM)-A stated he did not know it needed to be in the contract. HM-A provided a document with the information, but it was not attached or part of R1's contract.</p> <p>The licensee's undated Assisted Living Contract Requirements policy indicated the facility contract shall contain the following information in its written contract to residents: - contact information for the Office of</p>	0 930		

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0 930	Continued From page 24  Ombudsman for Long-Term Care, the Ombudsman for Mental Health and Developmental Disabilities, and the Office of health Facility Complaints  No further information was provided.  TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 930		
01290 SS=F	144G.60 Subdivision 1 Background studies required  (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits.  This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a background study was affiliated to the current health facility identification (HFID) number for 5 of 8 employees on the facility provided employee roster.  This practice resulted in a level two violation (a violation that did not harm a resident's health or	01290		

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01290	<p>Continued From page 25</p> <p>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 the residents).</p> <p>The findings include:</p> <p>On June 4, 2024, at 2:30 p.m., the surveyor reviewed the facility's roster on the NET Study 2.0 website (background study) and compared it to the facility's staff roster and discovered only 3 of the facility's 8 employees were affiliated with the licensee's HFID #35663. The other 5 staff were affiliated with a HFID of a sister facility.</p> <p>On June 4, 2024, at 12:45 p.m., housing manager (HM)-A stated the process of completing background studies was new to him and he ran the studies under one of their other addresses.</p> <p>The licensee's undated Background Checks policy indicated [the facility] will conduct background screenings on all applicants once an offer of employment has been offered. All employment offers are contingent upon a clearance of their DHS (department of human services) screening.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Two (2) days.</p>	01290		
01470 SS=D	144G.63 Subd. 2 Content of required orientation	01470		

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01470	<p>Continued From page 26</p> <p>(a) The orientation must contain the following topics:</p> <ul style="list-style-type: none"> <li>(1) an overview of this chapter;</li> <li>(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;</li> <li>(3) handling of emergencies and use of emergency services;</li> <li>(4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC);</li> <li>(5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights;</li> <li>(6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person;</li> <li>(7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints;</li> <li>(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</li> <li>(9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure.</li> </ul> <p>(b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must</p>	01470		

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01470	<p>Continued From page 27</p> <p>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.</p> <p>This MN Requirement is not met as evidenced by:                      Based on interview and record review, the licensee failed to ensure orientation to assisted living facility licensing requirements and regulations included all required content for one of one employee (unlicensed personnel (ULP)-C).</p> <p>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).</p> <p>The findings include:</p> <p>ULP-C was hired on July 10, 2020, to provide direct care services.</p> <p>ULP-C's employee records lacked the following</p>	01470		

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01470	<p>Continued From page 28</p> <p>required orientation content:</p> <ul style="list-style-type: none"> <li>-overview of 144G.63 orientation</li> <li>-an introduction and review of the facilities policies and procedures related to the provision of assisted living services by the individual staff person.</li> <li>-assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights.</li> <li>- the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person.</li> <li>-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</li> <li>-a review of the types of assisted living services the employee will be providing and the facility's category of licensure.</li> </ul> <p>On June 3, 2024 at 2:00 p.m., housing manager (HM)-A stated the educare (on-line education) transcript listed all of ULP-C's assigned completed training.</p> <p>The licensee's undated Staff Orientation and Education policy stated all staff providing home health care through [the facility] will be prepared to provide safe, effective services to all clients through orientation and education program pertinent to the needs of the clientele. Upon hire and before providing services to clients all employees attend a general orientation conducted by [the facility], those providing direct service will complete a competency evaluation as part of the orientation process. Orientation topics</p>	01470		

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01470	<p>Continued From page 29</p> <p>will include an overview of Minnesota Home Care Section 144A.43 to 144A.4798, review of the organization's policies and procedures related to the provision of home care services, home care bill of rights and 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.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p>	01470		
01500 SS=D	<p>144G.63 Subd. 5 Required annual training</p> <p>(a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include:</p> <p>(1) training on reporting of maltreatment of vulnerable adults under section 626.557;</p> <p>(2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights;</p> <p>(3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor</p>	01500		

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01500	<p>Continued From page 30</p> <p>blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases;</p> <p>(4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders;</p> <p>(5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and</p> <p>(6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person.</p> <p>(b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics:</p> <p>(1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication;</p> <p>(2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or</p> <p>(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.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record</p>	01500		

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01500	<p>Continued From page 31</p> <p>review, the licensee failed to ensure an employee received at least eight hours of annual training for each 12 months of employment for one of one employee (unlicensed personnel (ULP)-C).</p> <p>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).</p> <p>The findings include:</p> <p>ULP-C had a hire date of July 10, 2020, to provide direct care services to residents.</p> <p>On June 3, 2024, at 12:00 p.m., the surveyor observed ULP-C administer medications.</p> <p>ULP-C's record lacked evidence of annual training to include the assisted living bill of rights, review of policies and procedures and principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person.</p> <p>On June 3, 2024, at 2:00 p.m., housing manager (HM)-A stated the educare (on-line education) transcript listed all of ULP-C's completed training.</p> <p>The licensee's undated Staff Orientation and Education policy indicated required annual employee training will include review of the home care bill of rights and review of the organizations' policies and procedures related to implementation of home care services.</p>	01500		

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01500	Continued From page 32  No further information was provided.  TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500		
01620 SS=F	<p>144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring</p> <p>(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.</p> <p>(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.</p> <p>(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.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to ensure the clinical nurse supervisor (CNS)-B used the uniform</p>	01620		

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01620	<p>Continued From page 33</p> <p>assessment tool for ongoing assessments and monitoring for one of one resident (R1).</p> <p>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).</p> <p>The findings include:</p> <p>On June 3, 2024, at 10:30 a.m., CNS-B stated the licensee completed initial, 14-day, 90-day, and change in condition assessments.</p> <p>R1 was admitted and began receiving services on October 14, 2020.</p> <p>R1's record included 90-day assessments dated January 20, 2024, and May 19, 2024. R1's 90-day assessments did not include the following required elements on the uniform assessment tool:</p> <ul style="list-style-type: none"> <li>-the resident's personal lifestyle preferences, including sleep schedule and social needs, leisure activities, and any other customary routine that is important to the resident's quality of life, spiritual and cultural preferences and advance health care directives and end-of-life preferences</li> <li>- activities of daily living, including grooming, dental status, oral care, and dentures.</li> <li>- physical health status, including a review of relevant health history and current health conditions including medical and nursing diagnoses, allergies and sensitivities related to medication, seasonality, environment, and food and if any of the allergies or sensitivities and life</li> </ul>	01620		
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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>35663</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/04/2024</b>
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NAME OF PROVIDER OR SUPPLIER  <b>MINNESOTA GROUP HOMES LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>10355 GRAND AVENUE SOUTH BLOOMINGTON, MN 55420</b>
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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
01620	<p>Continued From page 34</p> <p>threatening, infectious conditions, a review of medical, dental, and emergency room visits in the past 12 months, including visits to a primary health care provider, hospitalizations, surgeries, and care from a post-acute care facility, a review of any reports from a physical therapist, occupational therapist, speech therapist, or cognitive evaluations within the last 12 months</p> <ul style="list-style-type: none"> <li>- emotional and mental health conditions, including review of history of and any diagnoses of mood disorders, including depression, anxiety, bipolar disorder, and thought or behavioral disorders, effective medication treatment and non medication interventions</li> <li>- cognition, including a review of any neurocognitive evaluations and diagnoses</li> <li>- communication and sensory capabilities, including speech, assistive communication and sensory devices including hearing aids, and the ability to understand and be understood</li> <li>-nutritional and hydration status and preferences</li> <li>- list of treatments, including type, frequency, and level of assistance needed</li> <li>- nursing needs, including potential to receive nursing-delegated services</li> <li>- risk indicators including risk for falls including history of falls, emergency evaluation ability, complex medication regimen, risk for dehydration, including history of urinary tract infections and current fluid intake pattern, risk for emotional or psychological distress due to personal losses, unsuccessful prior placements, elopement risk including history or previous elopements, smoking, including the ability to smoke without causing burns or injury to the resident or others or damage property and alcohol and drug use, including the resident's alcohol use or drug use not prescribed by a physician</li> <li>- who has decision making authority for the</li> </ul>	01620		

Minnesota Department of Health

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01620	<p>Continued From page 35</p> <p>resident including the presence of any advance health care directive or other legal document that establishes a substitute decision maker and the scope of decision-making authority of a substitute decision maker under subitem (1) - the need for follow-up referrals for additional medical or cognitive care by health professionals</p> <p>On June 5, 2024, at 11:00 a.m., CNS-B stated she was not aware that the current assessment tool did not meet the requirements.</p> <p>On June 5, 2024, at 11:00 a.m., housing manager (HM)-A stated they are scheduled to begin training with R-task (electronic medical record) and will use that assessment in the future.</p> <p>The Minnesota Administrative Rule 4659.0150 dated August 11, 1021, indicated each facility must develop a uniform assessment tool to include all the required elements.</p> <p>The licensee's Comprehensive Nursing Assessment policy dated August 1, 2021, indicated the registered nurse (RN) will conduct a comprehensive assessment utilizing a uniform assessment tool that addresses all the above missing requirements.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-One (21) days</p>	01620		
01710 SS=F	<p>144G.71 Subd. 3 Individualized medication monitoring and reas</p> <p>The assisted living facility must monitor and reassess the resident's medication management</p>	01710		

Minnesota Department of Health

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01710	<p>Continued From page 36</p> <p>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.</p> <p>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) completed annual medication reassessments for one of one resident (R1).</p> <p>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).</p> <p>The findings include:</p> <p>R1 admitted to the facility and began receiving services on October 14, 2020.</p> <p>R1's service plan dated October 14, 2020, indicated R1 received services to include medication administration.</p> <p>R1's medication assessment was dated October 14, 2020.</p> <p>R1's record lacked an annual medication reassessment.</p> <p>On June 3, 2024, at 12:00 p.m., the surveyor observed unlicensed personnel (ULP)-C administer medications to R1.</p>	01710		
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Minnesota Department of Health

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01710	<p>Continued From page 37</p> <p>On June 5, 2024, at 10:00 a.m., clinical nurse supervisor (CNS)-B stated she was unaware that annual and change of condition medication re-assessments were required. She stated that she has not completed a re-assessment since the original assessment was completed on October 15, 2020.</p> <p>The licensee's Comprehensive Nursing Assessment policy dated August 1, 2021, indicated the registered nurse will conduct a comprehensive assessment utilizing a uniform assessment tool that addresses the following: -medications</p> <p>No further information provided.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days</p>	01710		
01940 SS=F	<p><b>144G.72 Subd. 3 Individualized treatment or therapy managemen</b></p> <p>For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration;</p>	01940		

Minnesota Department of Health

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01940	<p>Continued From page 38</p> <p>(3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for one of one resident (R1).</p> <p>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 the residents).</p> <p>The findings include:</p> <p>R1 admitted to the facility and began receiving services on October 14, 2020. R1's diagnoses included diabetes and hypertension.</p>	01940		

Minnesota Department of Health

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01940	<p>Continued From page 39</p> <p>R1's medication and treatment administration record dated June 1, 2024, indicated R1 received blood glucose monitoring three times daily, oxygen therapy daily, bi-pap therapy daily and Velcro compression wraps daily.</p> <p>R1's Service Plan dated August 15, 2023, lacked identification of treatment services related to R1's blood glucose monitoring, oxygen therapy, bi-pap therapy and velcro compression wraps.</p> <p>R1's record failed to include procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services.</p> <p>On June 3, 2024, at 12:00 p.m., the surveyor observed unlicensed personnel (ULP)-C complete blood glucose monitoring for R1.</p> <p>On June 3, 2024, at 12:00 p.m., ULP-C stated his training included when to call the nurse if he had questions due to a high or low blood sugar reading.</p> <p>On June 5, 2024, at 10:00a.m., clinical nurse supervisor (CNS)-B stated she was aware that the treatment or therapy management plan needed to be updated with any new treatments or change in condition. She had not completed a treatment or therapy management on R1. She stated she was unaware that procedures for notifying the registered nurse when a problem arises with treatments or therapy services was required.</p> <p>The licensee's undated document titled Individualized Treatment and Therapy Management indicated the treatment and management plan included the following:</p>	01940		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>35663</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/04/2024</b>
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01940	<p>Continued From page 40</p> <ul style="list-style-type: none"> <li>-statement of services provided.</li> <li>-document of instructions for the service provided.</li> <li>-identifying which treatment and/or therapy will be delegated to ULP (unlicensed personnel).</li> <li>-procedure for notifying the RN (registered nurse) when questions or concerns arise from the service.</li> <li>-any additional documentation that is required for the successful and safe application that that treatment or therapy.</li> <li>-documentation of the administration of the treatment or therapy.</li> <li>-monitoring the treatment or therapy for possible complications or adverse reactions.</li> </ul> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-One (21) days</p>	01940		

Type: Full  
Date: 06/04/24  
Time: 13:44:38  
Report: 1021241147

## Food and Beverage Establishment Inspection Report

Page 1

**Location:**

Minnesota Group Homes Llc  
Minnesota Group Homes LLC  
10355 Grand Avenue South  
Bloomington, MN55420  
Hennepin County, 27

**Establishment Info:**

ID #: 0039046  
Risk:  
Announced Inspection: Yes

**License Categories:**

Expires on: / /

**Operator:**

Phone #: 6519999616  
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 ON-SITE. DISCUSSED EMPLOYEE ILLNESS POLICY WITH MANAGER. AN MDH ILLNESS LOG SENT WITH REPORT.

*Comply By: 06/06/24*

### 3-500C Microbial Control: date marking

#### 3-501.17B

**\*\* Priority 2 \*\***

MN Rule 4626.0400B Mark the refrigerated, ready-to-eat, TCS food prepared and packaged in a processing plant and opened and held for more than 24 hours in the food establishment using an effective method to indicate the date by which the food must be consumed on the premises, sold, or discarded. The date must not exceed the manufacturer's use-by-date.

A GALLON OF MILK THAT WAS OPENED LAST SUNDAY (6/2/24) AND A CARTON OF LACTOSE FREE MILK THAT WAS OPENED LAST FRIDAY (5/31/24) WERE FOUND WITH NO DATE MARKING. DISCUSSED DATE MARKING WITH STAFF AND THEY DATE MARKED BOTH MILKS. CORRECTED ON-SITE.

*Comply By: 06/04/24*

Type: Full  
Date: 06/04/24  
Time: 13:44:38  
Report: 1021241147  
Minnesota Group Homes Llc

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# Food and Beverage Establishment Inspection Report

Page 2

## 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.

ESTABLISHMENT DOES NOT HAVE A MEASURING DEVICE THAT INDICATES THE FINAL UTENSIL SURFACE TEMPERATURE IN DISH MACHINE. PROVIDE. ONE THERMOLABEL WAS LEFT ON-SITE.

*Comply By: 06/11/24*

## 2-100 Supervision

### 2-102.12AMN

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

NO CERTIFIED FOOD PROTECTION MANAGER EMPLOYED AT THIS ESTABLISHMENT. BASHIR GEELLE HAS A FOOD SAFETY CERTIFICATE BUT IT IS NOT WITHIN THE 6 MONTHS. HE IS WAITING TO RE-TAKE THE TEST AND SEND IT TO MDH.

*Comply By: 07/08/24*

## 6-200 Physical Facility Design and Construction

### 6-201.14A

MN Rule 4626.1350A Remove carpeting or similar material from the following unapproved areas: food preparation areas; walk-in refrigerators or freezers; warewashing areas; toilet room areas where handwashing sinks, toilets and urinals are located; refuse storage areas; wait stations; dressing rooms; locker rooms; janitorial areas; within 3 feet around permanently installed bars and salad bars, other food service equipment, and food storage rooms; or other areas where the floor is subject to moisture, flushing, or spray cleaning methods.

THERE IS A CHEST FREEZER IN THE BASEMENT THAT IS PLACED ABOVE CARPET. CARPET IS NOT AN APPROVED SURFACE FOR FOOD SERVICE EQUIPMENT (SEE RULE ABOVE). MANAGER IS GOING TO MOVE THE CHEST FREEZER TO A LOCATION WHERE THERE IS TILE.

*Comply By: 06/10/24*

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## Food and Equipment Temperatures

Process/Item: Cold Holding

Temperature: 41 Degrees Fahrenheit - Location: MILK - FRIGIDAIRE REFRIGERATOR

Violation Issued: No

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Process/Item: Cold Holding

Temperature: 41 Degrees Fahrenheit - Location: LACTOSE FREE MILK - FRIGIDAIRE REFRIGERATOR

Violation Issued: No

---

Process/Item: Ambient Temperature

Temperature: 39 Degrees Fahrenheit - Location: FRIGIDAIRE REFRIGERATOR

Violation Issued: No

---

Type: Full  
Date: 06/04/24  
Time: 13:44:38  
Report: 1021241147  
Minnesota Group Homes Llc

# Food and Beverage Establishment Inspection Report

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

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ALL FINDINGS ON THIS REPORT WERE DISCUSSED WITH MANAGER, BASHIR GEELLE AND HEALTH REGULATION DIVISION NURSE EVALUATORS, WENDY ROBARGE AND LISA SCHWINTEK.

THIS FACILITY IS A RESIDENTIAL HOME AND THEY CURRENTLY HAVE 1 CLIENT AND THE FACILITY CAN HAVE UP TO 4 CLIENTS.

PER CONVERSATION WITH MANAGER, FOOD IS MADE FOR SAME DAY SERVICE. NO LEFTOVERS ARE KEPT.

THE KITCHEN HAS RESIDENTIAL EQUIPMENT AND LAMINATE COUNTERTOPS. PHYSICAL FACILITY ITEMS WILL BE MONITORED AT FUTURE INSPECTIONS.

**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 1021241147 of 06/04/24.

Certified Food Protection Manager: \_\_\_\_\_

Certification Number: \_\_\_\_\_ Expires: \_\_\_\_/\_\_\_\_/\_\_\_\_

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

Signed: \_\_\_\_\_

BASHIR GEELLE  
MANAGER

Signed: \_\_\_\_\_

Melissa Ramos  
Environmental Health Specialist  
Metro District Office  
651-201-4495  
Melissa.Ramos@state.mn.us