



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

December 6, 2024

Licensee
Live Well Mn Home Healthcare
8600 Park Ave South
Bloomington, MN 55420

RE: Project Number(s) SL39991015

Dear Licensee:

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

The Minnesota Department of Health completed an initial survey on October 24, 2024, for the purpose assessing compliance with state licensing statutes. At the time of the survey, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G.

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

STATE CORRECTION ORDERS

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

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

DOCUMENTATION OF ACTION TO COMPLY

Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the

correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

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

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

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

If you have any questions, please contact me.

Sincerely,



Renee Anderson, Supervisor

State Evaluation Team

Email: renee.anderson@state.mn.us

Telephone: 651-201-5871 Fax: 1-866-890-9290

JMD

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39991	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER LIVE WELL MN HOME HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 8600 PARK AVE SOUTH 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 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: SL39991015-0 On October 21, 2024, through October 24, 2024, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were four residents; four receiving services under the provisional Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
0 110 SS=C	144G.10 Subdivision 1a Assisted living director license required	0 110			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39991	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER LIVE WELL MN HOME HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 8600 PARK AVE SOUTH 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
0 110	Continued From page 1 Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the licensed assisted living director (LALD) was registered with the Minnesota Board of Executives for Long Term Services and Supports (BELTSS) as the licensee's Director of Record. This had the potential to affect all the licensee's residents, staff, and visitors. 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: Clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A started employment on August 18, 2024. On October 21, 2024, at 10:30 a.m., the Minnesota BELTSS website was reviewed, and did not indicate CNS/LALD-A was the Director of Record for the licensed facility. During an interview on October 21, 2024, at 11:30 a.m., CNS/LALD-A stated they were unaware that they were not listed as the Director of Record.	0 110			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39991	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER LIVE WELL MN HOME HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 8600 PARK AVE SOUTH 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
0 110	Continued From page 2 CNS/LALD-A stated they would update BELTSS. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 110			
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review the	0 680			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39991	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER LIVE WELL MN HOME HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 8600 PARK AVE SOUTH 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
0 680	Continued From page 3 licensee failed to have a written emergency preparedness (EP) plan with all the required content. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee's EP plan lacked evidence of the following requirements: -participate in an annual full-scale exercise that was community based OR conduct an annual, individual, facility-based functional exercise, OR if the facility experiences an actual emergency requiring activation of plan -conduct an additional annual exercise that may include: a second full-scale exercise that was community-based or an individual, facility based functional exercise OR mock disaster drill OR table-top exercise. On October 22, 2024, at 11:30 a.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A stated they did not have any records of drills on the EP plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39991	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER LIVE WELL MN HOME HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 8600 PARK AVE SOUTH 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
0 780	Continued From page 4	0 780			
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, 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 functioned and were interconnected so that the actuation of one alarm caused 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	0 780			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39991	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER LIVE WELL MN HOME HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 8600 PARK AVE SOUTH 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	
0 780	Continued From page 5 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 October 23, 2024, at approximately 1:00 p.m., survey staff toured the facility with clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A. Survey staff asked CNS/LALD-A to initiate a test of the smoke alarms throughout the home. Upon testing, it was found that the smoke alarms in the facility were not interconnected. These deficient conditions were visually verified by CNS/LALD-A, accompanying on the tour. On October 23, 2024, at 1:30 p.m., CNS/LALD-A stated they understood the smoke alarm requirements. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780			
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the	0 800			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39991	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER LIVE WELL MN HOME HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 8600 PARK AVE SOUTH 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
0 800	Continued From page 6 residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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 October 23, 2024, at approximately 1:00 p.m., survey staff toured the facility with clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A. The following was observed: GENERAL MAINTENANCE: The clothes dryer exhaust vent was disconnected from the clothes dryer. This allows gasses from combustion into the facility. The exterior damper for the clothes dryer vent was damaged. Damaged or missing exterior	0 800			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39991	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER LIVE WELL MN HOME HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 8600 PARK AVE SOUTH 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
0 800	Continued From page 7 exhaust dampers can serve as access points to pests and rodents. On October 23, 2024, at 2:30 p.m., CNS/LALD-A stated they understood the above-listed deficiencies. 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.	0 810			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39991	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER LIVE WELL MN HOME HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 8600 PARK AVE SOUTH 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
0 810	Continued From page 8 (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 the fire safety and evacuation plan (FSEP) with the required content and provide the required training and drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On October 23, 2024, at 1:30 p.m., survey staff observed the fire evacuation diagrams did not include the identification of the path of egress. The fire evacuation diagrams did not identify each sleeping room location. Exit plan diagrams must be correctly labeled to reduce confusion and potential obstructions to egress in a fire or similar emergency. On October 23, 2024, clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A provided documents on the FSEP,	0 810			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39991	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER LIVE WELL MN HOME HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 8600 PARK AVE SOUTH 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
0 810	Continued From page 9 fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN: The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The provided FSEP was from a third-party provider and had not been updated to the specific facility. The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. The FSEP included standard resident evacuation procedures but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan included instructions to evacuate residents but did not include any procedures for assisting residents during evacuation nor did it include instructions for staff to follow in case of relocation. On October 23, 2024, at 2:30 p.m., CNS/LALD-A stated they understood the areas of their policy that were incomplete and would work on bringing them into compliance. TRAINING: The licensee failed to provide evacuation training to residents at least once per year. CNS/LALD-A lacked documentation showing any training was offered or training was scheduled for a future date for residents on the fire safety and evacuation	0 810			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39991	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER LIVE WELL MN HOME HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 8600 PARK AVE SOUTH 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
0 810	Continued From page 10 plan. The licensee failed to provide documentation showing training to employees on the FSEP upon hire and at least twice per year. On October 23, 2024, at 2:30 p.m., CNS/LALD-A stated they understood the requirements for training residents and staff and would implement a training program that was compliant with statute requirements. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810			
0 950 SS=C	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for	0 950			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39991	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER LIVE WELL MN HOME HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 8600 PARK AVE SOUTH 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
0 950	Continued From page 11 the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to offer the opportunity to identify a designated representative, or document the resident declined to designate a representative, and include the required verbiage notifying the resident of their right to designate a representative, for one of one resident (R1). 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: R1's service plan, dated August 27, 2024, indicated R1 received services including assistance with activities of daily living, housekeeping, and medication management. R1's contract, dated November 15, 2023, lacked documentation R1 was given the opportunity to designate a representative, and also lacked the required verbiage, on a page separate from the contract, notifying R1, "You have the right to	0 950			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39991	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER LIVE WELL MN HOME HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 8600 PARK AVE SOUTH 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
0 950	Continued From page 12 name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable". On October 22, 2024, at 10:00 a.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A stated R1's record lacked the required verbiage for the designated representative. CNS/LALD-A further stated the required verbiage was missing from all residents' contracts because they were not aware that the verbiage was required. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 950			
01060 SS=D	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated	01060			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39991	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER LIVE WELL MN HOME HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 8600 PARK AVE SOUTH 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
01060	Continued From page 13 and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with required content after an emergency relocation for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or	01060			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39991	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER LIVE WELL MN HOME HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 8600 PARK AVE SOUTH 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
01060	Continued From page 14 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's record lacked documentation of an emergency relocation notification provided by the licensee following hospitalization. R1's service plan, dated August 27, 2024, indicated R1 received services including assistance with activities of daily living, housekeeping, and medication management. R1's record included a nursing note dated September 21, 2024. The note indicated R1 had returned from the hospital after being admitted on September 20, 2024, for a chest pain. R1's record lacked documentation a written notice was provided to the resident, the residents' legal representative, and designated representative that contained, at a minimum: - the reason for the relocation; - the name and contact information for the location to which the resident had been relocated and any new service provider; - contact information for the Office of Ombudsman for Long-Term Care (OOLTC); - if known and applicable, the approximate date or range of dates within which the resident was expected to return to the facility, or a statement that a return date was not currently known; and - a statement that, if the facility refused to provide housing or services after a relocation, the	01060			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39991	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER LIVE WELL MN HOME HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 8600 PARK AVE SOUTH 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
01060	Continued From page 15 resident had the right to appeal and the contact information for the agency to which the resident may submit an appeal. On October 24, 2024, at 10:45 a.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A stated a written notice had not been provided with the required content. In addition, CNS/LALD-A stated they were not aware of the requirement to provide a relocation notice to R1 or their representative. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060			
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39991	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER LIVE WELL MN HOME HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 8600 PARK AVE SOUTH 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
01620	Continued From page 16 long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing client monitoring and reassessment, not to exceed 14 calendar days from the start of services and ongoing assessment not to exceed every 90 days for two of two residents (R1 and R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 was admitted December 19, 2023, and had diagnoses including multiple sclerosis (a condition that affects nerves in your central nervous system and impacts movement) and depression. R1's service plan, dated August 27, 2024, indicated R1 received services including assistance with activities of daily living (ADLs), housekeeping, and medication management. R1's record included a comprehensive nursing	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39991	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER LIVE WELL MN HOME HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 8600 PARK AVE SOUTH 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
01620	Continued From page 17 assessment dated January 17, 2024, and subsequent assessments dated May 21, 2024, 125 days after the previous assessment, and August 28, 2024, 99 days after the previous assessment. R2 was admitted February 8, 2024, and had diagnoses including chronic obstructive pulmonary disease (COPD-a lung disease that affects breathing). R2's service plan, dated October 22, 2024, indicated R2 received services including assistance with ADLs, housekeeping, and medication management. R2's record included a comprehensive nursing assessment dated May 21, 2024, and a subsequent assessment dated August 28, 2024, 99 days after the previous assessment. On October 22, 2024, at 11:00 a.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A stated R1 and R2 assessments should have been completed 90 days after the last assessment. CNS/LALD-A further stated that R1 and R2's assessments were late because the medical records system did not alert that the assessment was due. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620			
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date	01640			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39991	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER LIVE WELL MN HOME HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 8600 PARK AVE SOUTH 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
01640	Continued From page 18 that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a current written service plan was signed to reflect the current services provided for one of three residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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).	01640			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39991	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER LIVE WELL MN HOME HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 8600 PARK AVE SOUTH 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
01640	Continued From page 19 The findings include: R2 was admitted February 8, 2024, and had diagnoses including chronic obstructive pulmonary disease (COPD -a lung disease that affects breathing). On October 22, 2024, at 10:15 a.m., the surveyor observed unlicensed personnel (ULP)-C assist R2 with medication administration. R2's record included a service plan signed October 22, 2024, during the survey. R2's record lacked a service plan developed upon admission with a signature by both the licensee and the resident or their representative, agreeing on the services to be provided. On October 21, 2024, at 11:30 a.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A stated they could not locate a signed service plan for R2 and that they were aware the service plan needed to be signed by the resident or resident representative. The licensee's Service Plan policy, dated August 1, 2021, indicated, "The initial service plan and any revisions were signed by a representative from [licensee] and the resident or resident's representative." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640			
01700 SS=D	144G.71 Subd. 2 Provision of medication management services	01700			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39991	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER LIVE WELL MN HOME HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 8600 PARK AVE SOUTH 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
01700	Continued From page 20 (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted a medication management assessment which included all content prior to providing medication management services for one of two residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	01700			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39991	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER LIVE WELL MN HOME HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 8600 PARK AVE SOUTH 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
01700	Continued From page 21 resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1 was admitted December 19, 2023, and had diagnoses including multiple sclerosis (a condition that affects nerves in your central nervous system and impacts movement) and depression. R1's service plan, dated August 27, 2024, indicated R1 received services including assistance with activities of daily living, housekeeping, and medication management. R1's Medication Administration Record dated October 2024, indicated medications that had been administered to R1 included amlodipine (to treat high blood pressure), atorvastatin (to treat high cholesterol), carvedilol (to treat high blood pressure), gabapentin (to treat pain), metformin (to treat diabetics), pantoprazole (to treat heart burn), vitamin D3 (supplement), buprenorphine and Naloxone (to treat opioid addiction), escitalopram (to treat depression), and melatonin (to treat insomnia). R1's medication assessment completed by clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A on August 28, 2024, was not updated to reflect R1 currently required assistance with medication. The medication assessment further lacked the following required content: -identification and review of all medications the	01700			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39991	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER LIVE WELL MN HOME HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 8600 PARK AVE SOUTH 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
01700	Continued From page 22 resident is known to be taking including indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues; and -interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. On October 23, 2024, at 11:20 a.m., CNS/LALD-A stated they were unaware of the required content for medication management assessments. CNS/LALD-A stated that the service plan had been updated but they did not update the medication plan. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01700			
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39991	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER LIVE WELL MN HOME HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 8600 PARK AVE SOUTH 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
01760	Continued From page 23 completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to document, or indicate the resident refused medication administration for one of two residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1 was admitted December 19, 2023, and had diagnoses including multiple sclerosis (a condition that affects nerves in your central nervous system and impacts movement) and depression. R1's service plan, dated August 27, 2024, indicated R1 received services including assistance with activities of daily living, housekeeping, and medication management. R1's record included a Medication Administration Summary dated October 2024. The Medication Administration Summary lacked documentation of administration or why the following medications	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39991	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER LIVE WELL MN HOME HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 8600 PARK AVE SOUTH 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
01760	Continued From page 24 were not administered as prescribed: October 16, 2024: gabapentin 100 (milligrams) mg (to treat pain), buprenorphine and Naloxone 8-2 mg (to treat opioid addiction), escitalopram 20 mg (to treat depression), and melatonin 3mg (to treat insomnia), pantoprazole 40 mg (to treat heart burn). On October 23, 2024, at 11:30 a.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A stated medications should be documented following administration. CNS/LALD-A was unsure of why staff failed to document on the medication administration record. CNS/LALD-A stated they would provide re-training to all staff members administering medications. The 7.22 Medication and Treatment Record - Documentation and Refusal policy dated October 10, 2021, indicated the following must be documented in the resident record after providing medication assistance: -date; -time; -quantity of dosage; -method of administration; and -signature and title of the authorized person who provided the assistance and/or administration of the medications/treatments/therapy. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760			
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for	01890			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39991	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER LIVE WELL MN HOME HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 8600 PARK AVE SOUTH 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
01890	Continued From page 25 immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to dispose of expired medications and ensure medications were labeled correctly for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R2 was admitted February 8, 2024, and had diagnoses including chronic obstructive pulmonary disease (COPD -a lung disease that affects breathing). R2's service plan, dated October 22, 2024, indicated R2 received services including assistance with activities of daily living, housekeeping, and medication management. On October 22, 2024, at 10:15 a.m., the surveyor observed unlicensed personnel (ULP)-C assist R2 with medication administration.	01890			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39991	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER LIVE WELL MN HOME HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 8600 PARK AVE SOUTH 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
01890	Continued From page 26 On October 21, 2024, at 1:00 p.m., a review of the medication storage area indicated R2 had the following expired medication: cetirizine hydrochloride 10 milligrams (mg) (allergy relief) expiration date October 14, 2024. On October 21, 2024, at 1:05 p.m., ULP-C stated they would notify the nurse if they noticed expired medication. On October 22, 2024, at 11:10 a.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A stated expired medication should be removed by a nurse and destroyed. The licensee's undated Medications Disposition or Disposal policy date August 1, 2021, indicated expired medication would be destroyed according to policy. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890			



Minnesota Department Of Health
Food, Pools, and Lodging Services
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: 10/22/24
Time: 11:30:02
Report: 1050241217

Food and Beverage Establishment Inspection Report

Page 1

Location:

Live Well MN Home Healthcare
8600 Park Ave S
Bloomington, MN55420
Hennepin County, 27

Establishment Info:

ID #: 0043690
Risk:
Announced Inspection: No

License Categories:

Expires on: 12/31/24

Operator:

Phone #:
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.

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

Hot Water: = at 160F Degrees Fahrenheit
Location: Dishwasher
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding/Deli Meat
Temperature: 40F Degrees Fahrenheit - Location: Reach In Cooler
Violation Issued: No

Process/Item: Cold Holding/Milk
Temperature: 41F Degrees Fahrenheit - Location: Reach In Cooler
Violation Issued: No

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

Inspection was completed by MDH Andrew Spauldnig and with owner Vicent O. Mikaye. Angel Woehler was the lead Health Regulation Division Nurse Evaluator. Facility had four residents on site at time of inspection. Meals are prepared on site and leftovers are not kept on site. Current Pest Management services are provided by Ecoshield. No pests were seen at time of inspection.

This establishment has a residential kitchen. Food must be prepared for same day service only. The kitchen has wood cabinets with a hollow base and tile flooring. All found to be in good condition. A two basin sink is located in the kitchen with one basin designated for hand washing.

Food surfaces area to include wall, ceilings, countertops and finished materials must be Non-Absorbant, smooth, durable and easily clean able. Ceilings cannot have popcorn texture. Cabinets cannot have hollow bases. Exposed wood is not approved for food service areas. Wood is not a approved food contact service.

Type: Full
Date: 10/22/24
Time: 11:30:02
Report: 1050241217
Live Well MN Home Healthcare

Food and Beverage Establishment Inspection Report

Page 2

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 1050241217 of 10/22/24.

Certified Food Protection Manager: Vicent O. Mikaye

Certification Number: FM108584 Expires: 11/03/27

Inspection report reviewed with person in charge and emailed.

Signed: _____

Vicent O. Mikaye
Owner

Signed: _____

Andrew Spaulding
Public Health Sanitarian 2
FPLS Metro
651-201-5298
andrew.spaulding@state.mn.us