Electronically Delivered

April 18, 2023

Licensee
The Fountains at Hosanna
9850 163rd Street West
Lakeville, MN 55044

RE: Project Number(s) SL29049015

Dear Licensee:

The Minnesota Department of Health (MDH) completed an survey on March 23, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

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

The correction order documentation should include the following:

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

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

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

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

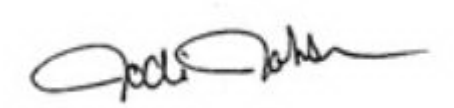
Please address your cover letter for reconsideration requests to:

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

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,



Jodi Johnson, Supervisor
State Evaluation Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: jodi.johnson@state.mn.us
Telephone: 507-344-2730 Fax: 651-281-9796

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29049	A. BUILDING: _____ B. WING _____	03/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOUNTAINS AT HOSANNA	9850 163RD STREET WEST LAKEVILLE, MN 55044

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments *****ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: Project # SL29049015 On March 21, 2023, through March 23, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 91 residents, 66 of whom received services under the provider's Assisted Living with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the	0 480		

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0 480	Continued From page 1 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 according to the Minnesota Food Code. This had the potential to affect all 91 current residents of the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: Please refer to the additional documentation included in the Food and Beverage Establishment Inspection Reports dated March 22, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 680 SS=E	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	0 680		

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0 680	Continued From page 2 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 the interview and record review, the licensee failed to comply with the monthly load test requirements for the facility's emergency power system (permanent generator) as part of the facility's emergency disaster and preparedness plan as required under Minnesota Rules, Part 4659.0100. This had the potential to affect the current resident receiving services under the assisted living license and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and	0 680		

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0 680	Continued From page 3 was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On March 22, 2023, at approximately 1:30 p.m., survey staff requested documentation related to the emergency system inspections and monthly load test with transfer switch operation records of the emergency power generator as part of the facility's shelter-in-place emergency disaster and preparedness plan. At approximately 3:15 p.m., document review and interview were conducted with the licensed assisted living director (LALD)-A and the director of maintenance (M)-E. The requested document was not available for review. The M-E indicated the licensee had records stored in the facility's maintenance system known as TELS and will need time to print out the generator log. On March 22, 2023, at approximately 3:30 p.m., the licensee failed to have records to show compliance with the minimum requirements for the emergency power generator as outlined under NFPA 110, (as referenced under the Code of Federal Regulations, title 42, section 483.73) to ensure proper performance of the generator. The M-E verbally confirmed the above findings during the document review and interview. The M-E stated that they will work to get the records of generator system inspections and load tests from their maintenance system. The LALD-A and M-E acknowledged the above findings. Survey staff indicated the additional documentation will be honored if received by the end of the following day (3/23/2023) for review.	0 680		

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0 680	Continued From page 4 Additional information was received via email from the LALD-A on Thursday, 03/23/2023, 3:43 p.m., with an attached pdf, TELS logbook-Generator. All records in the logbook lacked monthly load tests with transfer switch operation as evident with notes documenting "Exercise generator (with no load), perform routine checks, create entry in logbook". TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 780 SS=D	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code,	0 780		

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0 780	Continued From page 5 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 a working smoke alarm located in the hallway outside of the sleeping room of the one-bedroom resident apartment unit 305. This has the potential to directly affect the resident in unit 305. 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: On March 22, 2023, approximately from 11:00 a.m. to 1:20 p.m., survey staff toured the facility with the director of maintenance (M)-E and the licensed assisted living director (LALD)-A. During the tour, the smoke alarm located in the hallway outside of resident sleeping room of apartment unit 305 failed to sound when the M-E tested the alarm. The M-E verbally confirmed the finding. On March 22, 2023, at approximately 3:15 p.m., during the exit interview, the LALD-A and the M-E acknowledged the above finding. No further information was provided.	0 780		

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0 780	Continued From page 6 TIME PERIOD FOR CORRECTION: Twenty-one (21) 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 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 of the facility in a continuous state of good repair and operation. This has the potential to directly affect the health, safety, and well-being of all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On March 22, 2023, approximately from 11:00 a.m. to 1:20 p.m., survey staff toured the facility with the director of maintenance (M)-E and the	0 800		

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0 800	Continued From page 7 licensed assisted living director (LALD)-A. During the tour, survey staff observed the following: 1. The 1-1/2-hour fire-rated doors on the main floor (2-hour occupancy separation) between the business occupancy (including the church connection link) were wedged in an open position using floor door stoppers and preventing the fire-rated doors to properly close for proper fire separation of the two occupancies during a fire as designed. The M-E explained that the local official was recently on-site reviewing the doors and did not have any related concerns. Survey staff explained that the set of 1-1/2-hour fire-rated doors are shown on their original construction code plan sheet A0.3, 5/16/2011, as part of the two-hour firewall design and therefore, must function as designed. 2. The fire-rated doors for the laundry rooms (1st and 2nd) were wedged in open positions which compromised the fire safety of the corridors. All fire-rated doors must be in proper working order to maintain the integrity corridor to protect the residents, staff, and visitors during a fire. 3. Unlabeled extension cords were used in resident apartment units 130, 137, and 138. The use of unlisted and unlabeled extension cords poses a potential electrical fire hazard from overloading the electrical circuits and is a safety concern to residents. Extension cords must be listed and labeled to UL 817. 4. The reduced pressure zone backflow preventers (RPZ) tags in the lower-level floor showed the last date tested was November 12, 2021. RPZ devices must be tested annually by an approved testing company to prevent cross-connection and ensure the proper performance of RPZ devices to protect the building water supply system.	0 800		

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0 800	Continued From page 8 All listed deficiencies were visually and/or verbally verified by the M-E and/or the LALD-A accompanying the tour. On March 22, 2023, at approximately 3:15 p.m., during the exit interview, the LALD-A and the M-E acknowledged the above finding. Additional information was received via email on Wednesday 03/22/2023 at 4:15 p.m. from the LALD-A with two attached pdf documents, Annual Fire Alarm System Inspection and Test, dated 10/3/2022, and 2022 Fountains of Hossanna Points List.xls.pdf (undated). TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter.	0 810		

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0 810	Continued From page 9 (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to provide the complete content of the fire safety and evacuation plan and the minimum frequency of employee evacuation drills. This has the potential to directly affect the safety of all residents receiving services, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On March 22, 2023, at approximately 1:30 p.m., survey staff received the facility fire safety and evacuation plan and related documentation for	0 810		

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0 810	Continued From page 10 review from the director of maintenance (M)-E and the licensed assisted living director (LALD)-A. At approximately 3:00 p.m., document review and interview with the LALD-A and the M-E indicated the following findings: 1. The evacuation floor layout lacked exit locations in the memory care dining room into the courtyard. During the interview with the M-E, the LALD-A verified that the fire safety and evacuation plan for the facility lacked these provisions. 2. The drill documentation showed an insufficient number of employee fire evacuation drills performed to date. One drill record dated April 27, 2022 ((first shift), was provided for review. The drill record also lacked evacuation information as the drill was performed in room 303 without evacuation information. Survey staff explained to the LALD-A and the M-E that evacuation must also be included in the fire drills and the minimum required frequency of two fire evacuation drills for employees is twice per year per shift with at least one evacuation every other month, totally six evacuation drills per year that must be carried out to meet the requirements. All listed deficiencies were verbally verified by the M-E and/or the LALD-A during the document interview. On March 22, 2023, at approximately 3:15 p.m., during the exit interview, the LALD-A and the M-E acknowledged the above findings. No further information was provided. TIME PERIOD FOR CORRECTION: Fourteen (14) days	0 810		

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01060	Continued From page 11	01060		
01060 SS=F	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 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	01060		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOUNTAINS AT HOSANNA	9850 163RD STREET WEST LAKEVILLE, MN 55044

(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 12 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 the required content to the resident, legal representative, and designated representative, for an emergency relocation for one of one resident (R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R5's progress notes identified R5 was hospitalized from February 20, 2023, through February 23, 2023. R5's records lacked evidence the resident and the resident's representative had been provided a written notice as soon as practicable that contained, at a minimum: -the reason for the relocation; -the name and contact information for the location to which the resident has been relocated and any new service provider; -contact information for the Office of Ombudsman for Long-Term Care;	01060		

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01060	Continued From page 13 -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 -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. On March 22, 2023, at 3:35 p.m. clinical nurse supervisor (CNS)-B stated there was no emergency transfer notice completed or provided to the resident or the resident's responsible party. CNS-B stated she only completed the emergency transfer notice if the resident was in the hospital for four or more days. The licensee's Resident Agreement Termination - Emergency Relocation policy date August 1, 2021, identified: "1) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: a) the reason for the relocation; b) the name and contact intonation for the location to which the resident has been relocated and any new service provider; c) contact information for the Office of Ombudsman for Long-Term Care; d) 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 e) 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	01060		

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01060	Continued From page 14 information for the agency to which the resident may submit an appeal. 2) The notice required for emergency relocation will be delivered as soon as practicable to: a) the resident, legal representative, and designated representative; b) Resident's case manager if on waivered services; and c) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days". No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
01370 SS=D	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to	01370		

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01370	Continued From page 15 perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of one unlicensed personnel (ULP-C) completed training and competency evaluations in all required training topics. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-C was hired on February 20, 2023, to	01370		

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01370	Continued From page 16 provide direct care and services to the licensee's residents under the assisted living licensure. On March 22, 2023, at 7:50 a.m. ULP-C was observed administering oral medications, nasal spray, eye drops, insulin, and checking blood glucose. ULP-C stated she was not trained at this facility. ULP-C had worked here previously through an agency and then switched to permanent employment with this licensee. ULP-C further stated a facility nurse did conduct competency for her to administer medications and treatments. ULP-C's employee record lacked documentation of competency evaluations for the following: - appropriate and safe techniques in personal hygiene and grooming, including: - hair care and bathing; - care of teeth, gums, and oral prosthetic devices; - care and use of hearing aids; and - dressing and assisting with toileting; and - standby assistance techniques and how to perform them. On March 22, 2023, at 12:35 p.m. clinical nurse supervisor (CNS)-B stated ULP-C completed online training; however, she could not locate the missing competencies in ULP-C's employee file, therefore it had not been completed. The licensee's Orientation and Training: Employee policy dated August 1, 2023, identified "Unlicensed personnel who are providing assisted living services will successfully complete a practical skills test to demonstrate competency on the following topics: I. Appropriate and safe techniques in personal hygiene and grooming, including:	01370		

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01370	Continued From page 17 1. Hair care and bathing; 2. Care of teeth, gums, and oral prosthetic devices; 3. Care and use of hearing aids; and 4. Dressing and assisting with toileting; II. Standby assistance techniques and how to perform them". No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		
01380 SS=D	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of one unlicensed personnel (ULP-C) completed training	01380		

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01380	Continued From page 18 and competency evaluations in all required training topics. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-C was hired on February 20, 2023, to provide direct care and services to the licensee's residents under the assisted living licensure. On March 22, 2023, at 7:50 a.m. ULP-C was observed administering oral medications, nasal spray, eye drops, insulin, and checking blood glucose. ULP-C stated she was not trained at this facility. ULP-C had worked at this facility previously through an agency and then switched to permanent employment with this licensee. ULP-C stated a facility nurse completed competency for medications and treatments. ULP-C's employee record lacked documentation of competency evaluations for the following: - safe transfer techniques and ambulation; and - range of motioning and positioning. On March 22, 2023, at 12:35 p.m. clinical nurse supervisor (CNS)-B stated ULP-C completed online training; however, she could not locate the missing competencies in ULP-C's employee file, therefore it had not been completed. The licensee's Orientation and Training:	01380		

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01380	Continued From page 19 Employee policy dated August 1, 2023, identified "Unlicensed personnel who are providing assisted living services will successfully complete a practical skills test to demonstrate competency on the following topics: iv. Safe transfer techniques and ambulation; v. Range of motioning and positioning". No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380		
01750 SS=D	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the facility failed to follow delegated procedures related to administration of a narcotic medication for one of one resident (R2) who received a controlled substance. This practice resulted in a level two violation (a violation that did not harm a resident's health or	01750		

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01750	Continued From page 20	01750		

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's Service Plan Agreement effective February 21, 2023, indicated the resident received services including medication administration, and also received services through a hospice agency.

On March 22, 2023, at 9:06 a.m. unlicensed personnel (ULP)-D was observed setting up morning medications for R2 which included morphine (an opioid/narcotic medication used to treat moderate to severe pain) 5 milligrams (mg) by mouth or under the tongue three times a day. ULP-D obtained R2's morphine from the locked box in the medication cart, dispensed one tablet into a medication cup, then signed the medication out in the bound narcotic count book. ULP-D then asked the surveyor to sign the book as the witness of R2's remaining morphine count. The surveyor stated she could not do this and asked ULP-D if their practice was to obtain a second person for signing out a narcotic medication. ULP-D confirmed that it was, but the other ULP was busy assisting residents with breakfast. ULP-D then administered R2's medications without obtaining a second signature/witness.

On March 23, 2023, at 9:21 a.m. clinical nurse supervisor (CNS)-B confirmed a second signature should be obtained prior to administering a narcotic medication.

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01750	Continued From page 21 The licensee's Controlled Substances/Schedule II-V Drugs policy reviewed November 30, 2020, indicated: All reasonable precautions will be taken to mitigate the theft, diversion or misuse of controlled substances and will comply with requirements regarding the safe storage and disposal of these drugs. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for 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, interview, and record review, the licensee failed to ensure medications were maintained bearing the original prescription label with legible information including the expiration date for time sensitive medications in two of three medication carts. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred	01890		

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01890	Continued From page 22 only occasionally). The findings include: On March 22, 2023, at 1:14 p.m. a review of medication carts on second floor of the assisted living with unlicensed personnel (ULP)-C identified the following: Cart 1 - a fluticasone propionate/salmeterol 250 mg/50 mg inhaler (for respiratory disease) did not have a pharmacy label and handwritten on the label was R8's name. There was no open date noted on the inhaler. Cart 2 - refresh tears (eye drops) did not have a pharmacy label and R9's first name and initial of last name were hand written on the bottle. On March 22, 2023, at 2:30 p.m. clinical nurse supervisor (CNS)-B stated all medications should have a pharmacy label and time sensitive medications should be dated when they are opened. The licensee's Storage of Medication and Key Security policy dated September 27, 2021, identified "Until the medication is set up for immediate or later administration by a nurse, a legend drug must be kept in its original container bearing the original prescription label with legible information stating the prescription number, name of drug, strength and quantity of drug, expiration date of time-dated drug, directions for use, client's name, prescriber's name, date of issue and the name and address of the licensed pharmacy that issued the medications". Fluticasone propionate/salmeterol prescribing information dated April 2008, identified to safely	01890		

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01890	Continued From page 23 discard after one month or after dose indicator reads zero, whichever comes first. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
02170 SS=D	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following: (1) past and current interests; (2) current abilities and skills; (3) emotional and social needs and patterns; (4) physical abilities and limitations; (5) adaptations necessary for the resident to participate; and (6) identification of activities for behavioral interventions. (c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs. (d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to: (1) occupation or chore related tasks; (2) scheduled and planned events such as entertainment or outings; (3) spontaneous activities for enjoyment or those that may help defuse a behavior; (4) one-to-one activities that encourage positive	02170		

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02170	Continued From page 24 relationships between residents and staff such as telling a life story, reminiscing, or playing music; (5) spiritual, creative, and intellectual activities; (6) sensory stimulation activities; (7) physical activities that enhance or maintain a resident's ability to ambulate or move; and (8) outdoor activities. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop an individualized activity plan based on the evaluation, for one of three residents (R2) who resided in the locked memory care unit. 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: The licensee held an assisted living with dementia care (ALFDC) license effective August 1, 2022. R2 was admitted to the ALFDC on November 10, 2020, to an assisted living apartment. On February 16, 2023, R2 was transferred to the locked memory care unit due to exacerbation (an acute increase in the severity of an illness) of dementia symptoms and need for advanced services and supervision.	02170		

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THE FOUNTAINS AT HOSANNA	9850 163RD STREET WEST LAKEVILLE, MN 55044

(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
02170	Continued From page 25 R2's Service Plan effective February 21, 2023, indicated R2 received services which included dressing, bathing, grooming, toileting, laundry, housekeeping, safety checks, and medication administration. On March 22, 2023, at 9:06 a.m. unlicensed personnel (ULP)-D was observed administering medications to R2. R2's DIMENSIONS: MY WAY activity assessment form dated March 22, 2023, (completed and signed by R2's family member the day after survey entrance) indicated: Dimensions: MY WAY (Sections 1-2, pages 1-7) includes basic background information on the person, and their habits preferences, and routine. Typically, the Dimensions Manager, Activities/Life Enrichment Director, or other Activities professional conducts the interview and completes these pages in a conversation with a family member or other representative of the person. MY LIFE ENRICHMENT/ACTIVITY EVALUATION (Section 3, pages 8-10) provides detailed information needed to create an Activity Plan for the individual. Ideally, these pages are completed by the Dimension Manager, Activities/Life Enrichment Director, or a Activities Assistant devoted to MC (memory care), in conversation(s) with the individual and/or their family members, guardian or other representative. R2's record did not include evidence of an individualized activity plan based on R2's activity assessment. On March 23, 2023, at 9:44 a.m. activity director (AD)-F confirmed R2's activity plan had not been completed as the family had just turned in the	02170		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29049	A. BUILDING: _____ B. WING _____	03/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOUNTAINS AT HOSANNA	9850 163RD STREET WEST LAKEVILLE, MN 55044

(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
02170	Continued From page 26 DIMENSIONS: MY WAY form. AD-F further confirmed she depended on the family to complete the form and utilized it as the activity assessment. AD-F stated usually she already knew the residents who come to the MC unit as she had already worked with them on the assisted living (AL) side prior to their transfer to MC. AD-F confirmed she had worked with R2 on the AL side prior to transfer. The licensee's Use of DIMENSIONS: MY WAY FORM in Assisted Living revised May 16, 2022, indicated: Residents moving into a [company name] community will have a Dimensions: MY WAY form completed upon move-in. Information gathered in the Dimensions: MY WAY form will complement the Master Assessment for care planning and will serve as a tool to assist in creating a person-centered Activity Plan for the individual. The preferred way to obtain the information is via an interview/conversation with a family member or other representative of the individual. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02170		

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

Type: Full
Date: *03/22/23*
Time: 11:00:00
Report: 1005231056

Food and Beverage Establishment Inspection Report

Location:
The Fountains At Hosanna
9850 163rd Street West
Lakeville, MN55044
Dakota County, 19

Establishment Info:
ID #: 0039339
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 9524357199
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.

3-500A Microbial Control: cooling

3-501.15B ** Priority 2 **

MN Rule 4626.0390B Loosely cover containers of cooling food and arrange in cold holding equipment in a manner to maximize heat transfer through the container walls.

A BIN OF PASTA AND A CONTAINER OF PULLED PORK WERE TIGHTLY SEALED WITH PLASTIC WRAP WHILE THEY WERE STILL COOLING. DISCUSSED LEAVING CONTAINERS PARTIALLY UNCOVERED, AND OTHER BEST METHODS FOR EFFECTIVE COOLING.

Comply By: 03/21/23

Surface and Equipment Sanitizers

Quaternary Ammonia: = 200+PPM at Degrees Fahrenheit
Location: 3-COMP SINK
Violation Issued: No

Utensil Surface Temp.: = at 165 Degrees Fahrenheit
Location: KITCHEN DISH MACHINE
Violation Issued: No

Utensil Surface Temp.: = at 174 Degrees Fahrenheit
Location: MEMORY CARE DISH MACHINE
Violation Issued: No

Quaternary Ammonia: = 400PPM at Degrees Fahrenheit
Location: MEMORY CARE DISPENSER
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Hold/TURKEY
Temperature: 32 Degrees Fahrenheit - Location: PREP COOLER
Violation Issued: No

Process/Item: Cold Hold/TOMATOES
Temperature: 30 Degrees Fahrenheit - Location: PREP COOLER
Violation Issued: No

Process/Item: Cold Hold/CHICKEN
Temperature: 34 Degrees Fahrenheit - Location: PREP COOLER
Violation Issued: No

Process/Item: Thawing/BURGER
Temperature: 28 Degrees Fahrenheit - Location: PREP COOLER
Violation Issued: No

Process/Item: Cold Hold/CHEESE
Temperature: 36 Degrees Fahrenheit - Location: 1-DOOR REACH-IN COOLER
Violation Issued: No

Process/Item: Cold Hold/GRAVY
Temperature: 34 Degrees Fahrenheit - Location: 1-DOOR REACH-IN COOLER
Violation Issued: No

Process/Item: Hot Hold/SOUP
Temperature: 168 Degrees Fahrenheit - Location: METRO WARMING CABINET
Violation Issued: No

Process/Item: Cold Hold/TAPIOCA
Temperature: 41 Degrees Fahrenheit - Location: DESSERT COOLER
Violation Issued: No

Process/Item: Cold Hold/WHIPPED CREAM
Temperature: 40 Degrees Fahrenheit - Location: DESSERT COOLER
Violation Issued: No

Process/Item: Cold Hold/CUT MELON
Temperature: 36 Degrees Fahrenheit - Location: SALAD COOLER
Violation Issued: No

Process/Item: Cold Hold/HARD BOILED EGG
Temperature: 40 Degrees Fahrenheit - Location: SALAD COOLER
Violation Issued: No

Process/Item: Cold Hold/SOUP
Temperature: 33 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

Process/Item: Cold Hold/MEAT SAUCE
Temperature: 34 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

Type: Full
Date: *03/22/23*
Time: 11:00:00
Report: 1005231056
The Fountains At Hosanna

Food and Beverage Establishment Inspection Report

Process/Item: Cold Hold/BAKED POTATO
Temperature: 34 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

Process/Item: Cooling/PASTA
Temperature: 54 Degrees Fahrenheit - Location: WALK-IN COOLER, 2 HOURS
Violation Issued: No

Process/Item: Cooling/PORK
Temperature: 74 Degrees Fahrenheit - Location: WALK-IN COOLER, <2 HOURS
Violation Issued: No

Process/Item: Cold Hold/MILK
Temperature: 36 Degrees Fahrenheit - Location: MEMORY CARE COOLER
Violation Issued: No

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

INSPECTION COMPLETED WITH KITCHEN MANAGER AND REVIEWED WITH HRD NURSE EVALUATOR SARABETH REMKER.

DISCUSSED COOLING, COOKING, DATE MARKING, AND EMPLOYEE ILLNESS.

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 1005231056 of 03/22/23.

Certified Food Protection Manager: CHRISTOPHER R. NOWAK

Certification Number: FM36864 Expires: 02/24/24

Inspection report reviewed with person in charge and emailed.

Signed: _____
CHRIS NOWAK
KITCHEN MANAGER

Signed: Jessica Davis
Jessica Davis
Public Health Sanitarian III
651-201-3961
jessica.davis@state.mn.us