Electronically Delivered

October 10, 2024

Licensee
Universal Care Homes LLC
2301 16th Avenue South
Minneapolis, MN  55404

RE: Project Number(s) SL36721015

Dear Licensee:

On September 11, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the July 12, 2024, survey were corrected. This follow-up survey verified that the facility is n substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

Jess Schoenecker, Supervisor
State Evaluation Team
Email: Jess.Schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 1-866-890-9290

HHH

Electronically Delivered

August 13, 2024

Licensee
Universal Care Homes LLC
2301 16th Avenue South
Minneapolis, MN 55404

RE: Project Number(s) SL36721015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 12, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

**STATE CORRECTION ORDERS**

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

**IMPOSITION OF FINES**

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

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

In accordance with Minn. Stat. § 144G.31, Subd. 4(a)(5), MDH may impose fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. MDH may impose a fine of $1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. MDH also may impose a

fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

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

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

**St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required - $3,000.00**

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

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

The correction order documentation should include the following:

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

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

To submit a reconsideration request, please visit:
**https://forms.web.health.state.mn.us/form/HRDAppealsForm**

**REQUESTING A HEARING**
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the

correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. to submit a hearing request, please visit:
**https://forms.web.health.state.mn.us/form/HRDAppealsForm**

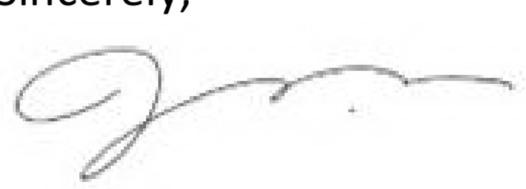
To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us 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,



Jess Schoenecker, Supervisor
State Evaluation Team
Email: Jess.Schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 1-866-890-9290

HHH

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 36721 | A. BUILDING: _____ B. WING _____ | 07/12/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| UNIVERSAL CARE HOMES LLC | 2301 16TH AVENUE SOUTH MINNEAPOLIS, MN 55404 |

| (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 |
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| 0 000 | Initial Comments<br><br>******ATTENTION******<br><br>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S)<br><br>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey.<br><br>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.<br><br>INITIAL COMMENTS:<br><br>SL36721015-0<br><br>On July 8, 2024, through July 12, 2024, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were three (3) residents; three receiving services under the provider's Assisted Living Facility license.<br><br>On July 8, 2024, an immediate correction order was issued for tag identification 1290.<br><br>The immediacy of the order was removed based on supervisor review on July 10, 2024, but noncompliance remained and the scope and level remain unchanged. | 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.<br><br>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.<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.<br><br>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 | | |

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| 0 110 | Continued From page 1<br><br>Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure licensed assisted living director ((LALD)-A) was listed as the Director of Record (DOR) for the licensee. This had the potential to affect all the licensee's residents, staff, and visitors.<br><br>This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the client/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).<br><br>The findings include:<br><br>On July 3, 2024, at 11:13 a.m., the Board of Executives for Long-Term Services and Support (BELTSS) website was reviewed. The BELTSS website indicated LALD-A held a current assisted living director license (issued July 26, 2021; and expired October 31, 2024). The website did not list LALD-A as the DOR for the licensee.<br><br>On July 9, 2024, at 11:00 a.m., LALD-A reviewed the BELTSS website with the surveyor and he stated he was not listed as the DOR. LALD-A stated he was unaware of the requirement and would contact BELTSS to update it. | 0 110 | | |

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| 0 110 | Continued From page 2<br><br>The licensee's 4.01 Assisted Living Director policy dated August 1, 2021, indicated the assisted living director would maintain a current and active license or permit with BELTSS. The policy also indicated the assisted living director was responsible for the licensed assisted living and all operations within the setting. The policy made no mention of the requirement for establishing the LALD as the director of record.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Two (2) days | 0 110 | | |
| 0 430 SS=C | 144G.40 Subd. 2 Uniform checklist disclosure of services<br><br>(a) All assisted living facilities must provide to prospective residents:<br>(1) a disclosure of the categories of assisted living licenses available and the category of license held by the facility;<br>(2) a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and<br>(3) an oral explanation of the services offered under the contract.<br>(b) The requirements of paragraph (a) must be completed prior to the execution of the assisted living contract.<br>(c) The commissioner must, in consultation with all interested stakeholders, design the uniform checklist disclosure form for use as provided under paragraph (a). | 0 430 | | |

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| 0 430 | Continued From page 3<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to provide licensee's Uniform Disclosure of Assisted Living Services and Amenities (UDALSA) for two of three residents (R1, R3).<br><br>This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>R1 and R3 were admitted on April 1, 2024, and May 31, 2022, respectively.<br><br>R1 and R3's records included a "Statement of Home Care Services: Basic Home Care Provider," which were signed and dated April 1, 2024, and May 31, 2022, respectively. The licensee's UDALSA was not listed as one of the identified documents provided to R1 and R3.<br><br>On July 9, 2024, at 10:36 a.m., licensed assisted living director (LALD)-A acknowledged the licensee failed to provide a UDALSA to all residents and was providing the wrong form. LALD-A stated he did not have a UDALSA available at the facility.<br><br>The licensee's 2.38 Resident Record-Information and Content policy dated August 1, 2021, indicated resident record must contain documentation required under this chapter | 0 430 | | |

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| 0 430 | Continued From page 4<br>(144G) and relevant to the resident's services or status.<br><br>No further information provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 430 | | |
| 0 480 SS=F | 144G.41 Subd 1 (13) (i) (B) Minimum requirements<br><br>(13) offer to provide or make available at least the following services to residents:<br>(B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents).<br><br>The findings include:<br><br>Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated July 9, 2024, for the specific Minnesota Food Code violations. The Inspection | 0 480 | | |

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| 0 480 | Continued From page 5<br>Report was provided to the licensee within 24 hours of the inspection.<br><br>TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates. | 0 480 | | |
| 0 650 SS=F | 144G.42 Subd. 8 Employee records<br><br>(a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information:<br>(1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules;<br>(2) records of orientation, required annual training and infection control training, and competency evaluations;<br>(3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision;<br>(4) documentation of annual performance reviews that identify areas of improvement needed and training needs;<br>(5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and<br>(6) documentation of the background study as required under section 144.057.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure employee records contained the required content for three of three employees (unlicensed personnel | 0 650 | | |

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| 0 650 | Continued From page 6<br>(ULP)-B, ULP-E, registered nurse (RN)-C).<br><br>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).<br><br>The findings include:<br><br>On July 8, 2024, at 2:55 p.m., the surveyor observed ULP-B provide blood glucose equipment to R1 to self-check her blood glucose and provided ULP-B the result. At 3:00 p.m., ULP-B set up R1's insulin for R1 to self-administer.<br><br>ULP-B and ULP-E<br>ULP-B and ULP-E were hired on May 15, 2021, and October 1, 2020, respectively, and began providing assisted living services to residents on August 1, 2021.<br><br>ULP-B and ULP-E's employee records lacked the following required content:<br>-records of training:<br>-unplanned times away;<br>-blood glucose monitoring; and<br>-insulin administration.<br>-records of competency evaluations:<br>-unplanned times away;<br>-blood glucose monitoring; and<br>-insulin administration.<br><br>RN-C<br>RN-C was hired on January 25, 2021, to be | 0 650 | | |

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| 0 650 | Continued From page 7<br>on-call for the licensee's residents and ULPs.<br><br>RN-C's employee record lacked the following required content:<br>-records of orientation to include:<br>-overview of assisted living statutes;<br>-handling emergencies and using emergency services;<br>-reporting maltreatment of vulnerable adults or minors;<br>-assisted living bill of rights;<br>-handling of resident complaints;<br>-consumer advocacy services;<br>-review of types of assisted living services the employee will provide and provider's scope of license; and<br>-principles of person-centered planning/service delivery.<br>-record of annual training to include:<br>-reporting maltreatment of vulnerable adults or minors;<br>-assisted living bill of rights;<br>-infection control techniques;<br>-dementia training;<br>-review of provider's policies and procedures,<br>-review of types of assisted living services the employee will provide and provider's scope of license; and<br>-principles of person-centered planning/service delivery.<br><br>On July 10, 2024, at 11:00 a.m., licensed assisted living director (LALD)-A stated he could not provide orientation records for RN-C.<br><br>On July 10, 2024, at 12:00 p.m., LALD-A and ULP-B confirmed they received training on unplanned times away, blood glucose monitoring, and insulin administration by clinical nurse supervisor (CNS)-D. | 0 650 | | |

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| 0 650 | Continued From page 8<br><br>On July 10, 2024, at 12:14 p.m., CNS-D stated he did complete training and competencies on all staff for unplanned times away blood glucose monitoring, and insulin administration.<br><br>On July 11, 2024, at 9:57 a.m., during phone interview with RN-C, she stated she completed her orientation and annual training at her other job unrelated to licensee that is an assisted living facility. The surveyor requested documentation of training completed at her other job.<br><br>On July 11, 2024, at 2:58 a.m., during phone interview with RN-C, she stated she completed the site-specific annual training such as the emergency preparedness and review of provider's policies and procedures. RN-C stated she sent the training records via email, but surveyor had not received them and requested they be sent again. Records were never received.<br><br>The licensee's Employee Records policy dated August 1, 2021, indicated the licensee would maintain a current record of each paid employee. The employee record would include evidence of licensure or certifications, orientation, required annual training, infection control, competency evaluation, performance evaluations, health screenings, background study, and job descriptions.<br><br>No further information provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 650 | | |
| 0 660 SS=F | 144G.42 Subd. 9 Tuberculosis prevention and control | 0 660 | | |

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| 0 660 | Continued From page 9<br><br>(a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines.<br>(b) The facility must maintain written evidence of compliance with this subdivision.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention and control program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included a current facility TB risk assessment. The licensee also failed to ensure history and symptoms screening was completed and documented for one of two employees (clinical nurse supervisor (CNS)-D).<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). | 0 660 | | |

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| 0 660 | Continued From page 10<br><br>The findings include:<br><br>TB RISK ASSESSMENT<br>On July 8, 2024, at 1:04 p.m., the surveyor requested the licensee's TB risk assessment and licensed assisted living director (LALD)-A stated he would send a message to CNS-D to obtain it.<br><br>On July 9, 2024, at 9:00 a.m., LALD-A stated they could not locate the TB risk assessment and he asked where he could find one to complete. Surveyor emailed LALD-A a copy. LALD-A was unaware on how often the TB risk assessment needed to be completed.<br><br>SYMPTOM SCREENING<br>CNS-D was hired October 1, 2020, to provide oversight of licensee's unlicensed personnel and residents.<br><br>CNS-D's employee record lacked evidence of screening for active TB with either a two-step TST or blood test and TB history and symptom screen.<br><br>On July 10, 2024, at approximately 11:00 a.m., LALD-A received CNS-D's TB Gold test and follow-up chest x-ray completed in 2022 for another job.<br><br>The Licensee's 8.16 Tuberculosis Screening policy dated August 1, 2021, read, "the facility will maintain a current community TB risk assessment. The assessment will be updated annually, using the data and form provided by the Minnesota Department of Health." As well as "Screening will be conducted as follows:<br>1. New staff will be screened for active signs of TB using the Baseline TB Screening Tools for | 0 660 | | |

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| 0 660 | Continued From page 11<br><br>HCW's.<br>2. New staff will have an IGRA blood test or a two-step Mantoux conducted with results documented on the Baseline TB Screening Tool for HCWs.<br>3. No staff will be permitted to begin work where the work involves sharing the air space with residents until the negative results from the first Mantoux are read and documented or a negative IGRA blood test result is received and documented.<br>4. Staff TB screening results will be kept in each employee medical file.<br>5. Staff should be screened for signs and symptoms on an annual basis."<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 660 | | |
| 0 680 SS=F | 144G.42 Subd. 10 Disaster planning and emergency preparedness<br><br>(a) The facility must meet the following requirements:<br>(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;<br>(2) post an emergency disaster plan prominently;<br>(3) provide building emergency exit diagrams to all residents;<br>(4) post emergency exit diagrams on each floor; and<br>(5) have a written policy and procedure regarding missing residents. | 0 680 | | |

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| 0 680 | Continued From page 12<br><br>(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.<br>(c) The facility must meet any additional requirements adopted in rule.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review the 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.<br><br>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).<br><br>The findings include:<br><br>The licensee's undated Emergency Preparedness plan, lacked evidence of the following required content:<br>-maintain and annual EP updates:<br>-community and facility based all-hazard risk assessment not completed;<br>-process for EP collaboration;<br>-policies and procedures for medical documents;<br>-policies and procedures for volunteers; | 0 680 | | |

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| 0 680 | Continued From page 13<br><br>-roles under a waiver declared by secretary;<br>-names and contact information:<br>-include names/contact information of staff, entities providing services under agreement, resident's physicians, other facilities, and volunteers;<br>-emergency officials contact information:<br>-federal, state, tribal, regional and local EP staff<br>-state licensing and certification agency;<br>-MN Office of Ombudsman for long-term care (LTC) and other sources of assistance;<br>-primary/alternative means for communication:<br>-primary and alternative means of communicating with facility staff, federal, state, tribal, regional and local emergency management agencies;<br>-methods for sharing information;<br>-sharing information on occupancy/needs;<br>-LTC family notifications; and<br>-emergency prep testing requirements:<br>-conduct exercises to test the EP at least twice per year, including unannounced staff drills using the EP.<br><br>On July 11, 2024, at 11:18 a.m., via email, surveyor sent an email to licensee requesting the facility and community-based risk assessment by utilizing an all-hazards approach and EP testing exercises.<br><br>On July 12, 2024, at 9:50 p.m., surveyor received a response from licensee read the following for the first request, "yes, and all [employees] took the test," and the response for the second request was, "yes, all the staff took Educare [online training platform] on the training and also on-site training with aper [sic]." The survey had already been completed for further clarification.<br><br>The licensee's 9.01 Emergency Preparedness | 0 680 | | |

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| 0 680 | Continued From page 14<br><br>Plan-Appendix Z Compliance policy dated August 1, 2021, read the licensee's emergency preparedness plan would include all required elements of appendix Z. The plan would be in writing and reviewed annually, and the plan was based on the assisted living-based and community-based risk assessments, utilizing an all-hazards approach.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 680 | | |
| 0 780 SS=F | 144G.45 Subd. 2 (a) (1) Fire protection and physical environment<br><br>(a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and:<br><br>(1) for dwellings or sleeping units, as defined in the State Fire Code:<br>(i) provide smoke alarms in each room used for sleeping purposes;<br>(ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms;<br>(iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics;<br>(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<br>(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 15<br><br>except that newly introduced smoke alarms in existing buildings may be battery operated;<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation and interview, the licensee failed to provide smoke alarms inside each resident sleeping room, and failed to provide interconnected smoke alarms so that the actuation of one alarm causes all alarms in the dwelling unit to actuate. This had the potential to directly affect all residents, staff, and visitors.<br><br>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).<br><br>The findings include:<br><br>On a facility tour on July 9, 2024, at 11:50 a.m., with licensed assisted living director (LALD)-A, it was observed that smoke alarms in the upstairs hallway and inside resident sleeping room 4 were not interconnected with other alarms throughout the facility. It was also observed that smoke alarms were not provided in resident sleeping room 1, located in the basement.<br><br>Smoke alarms are required to be installed inside and outside in the immediate vicinity of all sleeping rooms. All smoke alarms are required to be interconnected so activation of one alarm activates all alarms throughout the facility. | 0 780 | | |

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| 0 780 | Continued From page 16<br><br>During the tour the smoke alarms were tested and LALD-A, verified that a smoke alarm was not present in resident sleeping room 1 and that the smoke alarms were not interconnected so activation of one alarm activates all alarms throughout the facility.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Two (2) days | 0 780 | | |
| 0 790 SS=F | 144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment<br><br>(2) install and maintain portable fire extinguishers in accordance with the State Fire Code;<br><br>(3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation and interview, the licensee failed to maintain the portable fire extinguishers. This deficient condition had the potential to affect all staff, residents, and visitors.<br><br>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 | 0 790 | | |

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| 0 790 | Continued From page 17<br><br>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).<br><br>The findings include:<br><br>On a facility tour on July 9, 2024, at 11:50 a.m., with licensed assisted living director (LALD)-A the following was observed:<br><br>It was observed that the portable fire extinguisher located in the kitchen was not mounted and lacked records to show the required monthly visual inspections had been performed.<br><br>It was observed that the portable fire extinguisher mounted on the main floor by the front door was size 1-A:10-B:C with a date of 2020. The extinguisher lacked records to show annual testing and monthly visual inspections had been performed.<br><br>It was observed that the portable fire extinguisher mounted in the basement was size 1-A:10-B:C with a date of 2018. The extinguisher lacked records to show annual testing and monthly visual inspections had been performed.<br><br>Documentation is required to demonstrate portable fire extinguishers have been annually replaced with a new extinguisher or serviced annually by a certified technician and inspected by facility personnel monthly to ensure all portable extinguishers are readily available, fully charged, and operable at their designated location. Fire extinguishers with a minimum 2-A:10-B:C rating are required to be located so that travel distance to the nearest fire extinguisher does not exceed | 0 790 | | |

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| 0 790 | Continued From page 18<br><br>75 feet. All provided fire extinguishers are required to be mounted and maintained.<br><br>During the tour, LALD-A verified the findings and stated that they thought the kitchen fire extinguisher was within 75 feet of every area within the facility. Survey staff explained that the extinguisher needs to be mounted in its location and provided with monthly visual inspections. Survey staff also explained that all extinguishers that are provided must be maintained with annual testing and monthly visual inspections. LALD-A stated they understood the requirement.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 0 790 | | |
| 0 800 SS=F | 144G.45 Subd. 2 (a) (4) Fire protection and physical environment<br><br>(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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation and interview, the licensee failed to maintain the facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. | 0 800 | | |

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| 0 800 | Continued From page 19<br><br>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).<br><br>The findings include:<br><br>On a facility tour on July 9, 2024, at 11:50 a.m., with licensed assisted living director (LALD)-A the following was observed:<br><br>It was observed that the top step of the rear deck was loose and broken. The guardrails on both sides of the rear deck were loose and had broken spindles. Steps and guards must be maintained and be structurally solid to prevent accidental falls and not create tripping hazards.<br><br>It was observed that the faucet in the basement bathroom had a knob that was missing. Hot and cold water is required to be provided at bathroom sinks.<br><br>It was observed that the bath fan in the upstairs bathroom was missing the cover and would not turn on with the switch. Bath fans that are provided must be maintained in working order to remove moisture and humidity from the bathroom.<br><br>It was observed that the carbon monoxide alarm outside resident rooms 2, 3 and 4, located upstairs, was audibly chirping, indicating battery failure or malfunction. All safety systems that are | 0 800 | | |

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| 0 800 | Continued From page 20<br><br>installed must be maintained in working order to provide the safety and protection intended.<br><br>It was observed that the smoke detector inside resident sleeping room 3, located upstairs, was partially covered with a towel. Smoke alarms must be unobstructed, so they function properly.<br><br>It was observed that the office/storage room located in the basement was cluttered with boxes, files, clothing, and other objects that were not stored neatly and orderly. The door into the room was partially blocked and would not fully open to allow access to the room. The floor was covered with objects that blocked access to egress openings. Rooms should be kept neat and orderly and free of obstructions and clutter that prevent access to or egress from the room and create additional fire load and hazards.<br><br>It was observed that the window in resident sleeping room 1, located in the basement had cracked glass.<br><br>LALD-A verified these deficient findings at the time of discovery.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days. | 0 800 | | |
| 0 810 SS=F | 144G.45 Subd. 2 (b)-(f) Fire protection and physical environment<br><br>(b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to:<br>(1) location and number of resident sleeping | 0 810 | | |

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| 0 810 | Continued From page 21<br><br>rooms;<br>(2) employee actions to be taken in the event of a fire or similar emergency;<br>(3) fire protection procedures necessary for residents; and<br>(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.<br>(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.<br>(d) Fire safety and evacuation plans shall be readily available at all times within the facility.<br>(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.<br>(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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required training and drills. This had the potential to directly affect all residents, staff, and visitors.<br><br>This practice resulted in a level two violation (a | 0 810 | | |

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| 0 810 | Continued From page 22<br><br>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).<br><br>The findings include:<br><br>On July 9, 2024, at 12:30 p.m., licensed assisted living director (LALD)-A provided documentation on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility.<br><br>FIRE SAFETY AND EVACUATION PLAN<br>The licensee's FSEP, titled "Fire Emergency", undated, failed to include the following:<br><br>The FSEP did not include an evacuation map with a floor plan. Evacuation maps accurate to the building layout that show the location and number of resident sleeping rooms are required to be included in the FSEP.<br><br>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 plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate) but the plan was designed for a building with life safety systems such as automatic dialing to the fire department, smoke compartment doors, fire doors, magnetic door holders and fire sprinklers. The policy had not been updated to provide complete actions for employees to take in the event of a fire or similar emergency at the licensed facility which did not | 0 810 | | |

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| 0 810 | Continued From page 23<br>have life safety systems stated in the policy.<br><br>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.<br><br>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. 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.<br><br>During an interview on July 9, 2024, at 1:00 p.m., LALD-A stated that they would include the evacuation maps in the FSEP. Survey staff explained the areas of the FSEP that are deficient and need to be updated. LALD-A stated they understood the requirements.<br><br>TRAINING<br>Record review indicated the licensee failed to provide evacuation training to residents at least once per year. LALD-A was unable to provide documentation showing any training offered or training scheduled for a future date for residents on the fire safety and evacuation plan.<br><br>Record review indicated the licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. LALD-A provided documentation showing training provided to one staff member in May of 2021, February of 2022, and June of 2024. | 0 810 | | |

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| 0 810 | Continued From page 24<br><br>During an interview on July 9, 2024, at 1:00 p.m., with LALD-A, survey staff explained that employees are required to receive training on the FSEP upon hire and at least twice per year and that residents who are capable of assisting in their own evacuation should be trained on the FSEP annually. LALD-A stated they understood the requirement.<br><br>DRILLS<br>Record review indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month. LALD-A provided documentation indicating that evacuation drills were conducted January 2024 at 11:00 a.m., April 2024 at 10:55 a.m., and June 2024 at 1:40 a.m. These drills do not meet the requirement of every other month and were all conducted for the same shift. LALD-A was unable to provide documentation that any evacuation drills were conducted in 2023.<br><br>During an interview on July 9, 2024, at 1:00 p.m., survey staff explained the requirements for frequency of drills. LALD-A stated they understood the requirements.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 810 | | |
| 0 820 SS=D | 144G.45 Subd. 2 (g) Fire protection and physical environment<br><br>(g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under | 0 820 | | |

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| 0 820 | Continued From page 25<br><br>chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation and interview, the licensee failed to provide facilities that were not a distinct hazard to life. This had the potential to directly affect a limited number of residents and staff.<br><br>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).<br><br>The findings include:<br><br>On a facility tour on July 9, 2024, at 11:50 a.m., with licensed assisted living director (LALD)-A, it was observed that the emergency escape and rescue opening in unoccupied resident sleeping room 1, located in the basement, had broken hardware that would not allow the window to fully open. LALD-A opened the window and survey staff measured the opening. Emergency escape and rescue opening measurements were 10 inches wide, 43 inches in height and 430 square | 0 820 | | |

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| 0 820 | Continued From page 26<br><br>inches in openable area. The window did not meet the minimum requirements for clear opening width and clear opening area.<br><br>Survey staff explained to LALD-A that at least one compliant emergency escape and rescue opening is required within each resident sleeping room.<br><br>Existing emergency escape and rescue openings are required to meet a minimum clear opening area of 648 square inches and have a minimum dimension of 20 inches in height and a minimum dimension of 20 inches in width. The windowsill height from the floor to the clear opening shall be not more than 48 inches.<br><br>LALD-A visually verified the deficient condition while accompanying on the tour and stated they would have the window repaired or replaced.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Two (2) days | 0 820 | | |
| 0 950 SS=C | 144G.50 Subd. 3 Designation of representative<br><br>(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:<br><br>"RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES.<br><br>You have the right to name anyone as your "Designated Representative." A Designated | 0 950 | | |

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| 0 950 | Continued From page 27<br><br>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."<br><br>(b) The contract must contain a page or space for 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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to include the required verbatim notice to designate a representative in the assisted living contract for two of two residents (R1, R3).<br><br>This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>R1 and R3's Assisted Living Contract for Housing and Services signed April 1, 2024, and May 31, | 0 950 | | |

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| 0 950 | Continued From page 28<br><br>2022, respectively, did include language to provide the resident an opportunity to identify a designated representative but did not include the required verbatim notice to designate a representative.<br><br>On July 9, 2024, at 11:20 a.m., licensed assisted living director (LALD)-A stated the contract reviewed was the current contract in use for all residents. LALD-A stated he was familiar with the verbatim notice but didn't realize it wasn't in the contract. LALD-A said he would add it as an addendum.<br><br>The licensee's 2.38 Resident Record-Information and Content policy dated August 1, 2021, indicated the resident record must include the name, address, and telephone number of the resident's emergency contact, legal representative, and designated representative. The policy also indicated the resident record must contain other documentation required under chapter 144G and relevant to the resident's services or status.<br><br>No further information provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 950 | | |
| 01290 SS=I | 144G.60 Subdivision 1 Background studies required<br><br>(a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring | 01290 | | |

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| 01290 | Continued From page 29<br><br>self-disclosure of criminal conviction information.<br>(b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12.<br>(c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and record review, the licensee failed to ensure a background study was conducted prior to staff providing services for two of eight employees (unlicensed personnel (ULP)-B and registered nurse (RN)-C).<br><br>This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>ULP-B and RN-C's employee records lacked evidence of a completed background study clearance as required prior to providing services for the licensee's residents.<br><br>ULP-B and RN-C's employee records included a background study clearance completed on May 10, 2021, and January 17, 2021, respectively, under licensee's old health facility identification | 01290 | | |

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| 01290 | Continued From page 30<br><br>number (HFID) 35176. Licensee's current HFID is 36721.<br><br>ULP-B was hired on May 15, 2021, to provide assisted living services.<br><br>RN-C was hired on January 25, 2021, to provide on-call assisted living services to licensee's staff.<br><br>RN-C obtained their RN license on November 25, 2015, per Minnesota Board of Nursing credential search.<br><br>On July 8, 2024, at 1:33 p.m., the licensed assisted living director (LALD)-A stated they have not affiliated ULP-B and RN-C to licensee's current HFID when licensee transferred from their comprehensive license to their assisted living license.<br><br>On July 8, 2024, between 11:00 a.m. to 1:45 p.m., surveyor observed ULP-B providing services to residents, cooked lunch, provided supervision, and performed cleaning duties.<br><br>Review of licensee's NetStudy 2.0 Roster for HFID #35176, dated July 8, 2024, indicated both ULP-B and RN-C had COVID-19 studies that expired on December 31, 2022.<br><br>On July 8, 2024, at 1:33 p.m., licensed assisted living director (LALD)-A stated they have not affiliated both ULP-B and RN-C from licensee's HFID #35176 when licensee transferred from comprehensive license to assisted living license (HFID 36721). LALD-A stated he was responsible for completing background studies and was unsure why ULP-B and RN-C were not affiliated to current HFID. LALD-A stated RN-C provided back up on-call services if the primary RN was | 01290 | | |

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| 01290 | Continued From page 31<br><br>not available and would come to facility to perform nursing duties as necessary.<br><br>The licensee's 4.02 Background Studies policy dated August 1, 2021, indicated the licensee will conduct a Minnesota Department of Human Services Background Study on all employees and no employee may provide direct services and have independent direct contact with any resident until acceptable results of the background study have been received.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: IMMEDIATE<br><br>The immediacy of the order was removed based on supervisor review on July 10, 2024, but noncompliance remained and the scope and level remain unchanged. | 01290 | | |
| 01460 SS=F | 144G.63 Subdivision 1 Orientation of staff and supervisors<br><br>All staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. The orientation may be incorporated into the training required under subdivision 5. The orientation need only be completed once for each staff person and is not transferable to another facility.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure orientation to assisted living licensing requirements and | 01460 | | |

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| 01460 | Continued From page 32<br><br>regulations was completed for four of four employees (clinical nurse supervisor (CNS)-D, unlicensed personnel (ULP)-B, ULP-E, ULP-F). This had the potential to affect all residents.<br><br>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).<br><br>The findings include:<br><br>CNS-D was hired on October 1, 2020, to provide direct supervision to unlicensed personnel under the comprehensive home care license. CNS-D began providing assisted living services on August 1, 2021.<br><br>CNS-D's employee record lacked orientation to assisted living requirements to include:<br>-an overview of chapter 144G.08 through 144G.93;<br>-an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person;<br>-handling of emergencies and use of emergency services;<br>-compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC);<br>-the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; | 01460 | | |

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| 01460 | Continued From page 33<br><br>-the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person;<br>-handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints;<br>-consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and<br>-a review of the types of assisted living services the employee will be providing and the facility's category of licensure.<br><br>On July 8 through July 9, 2024, the surveyor observed ULP-B perform medication administration, prepare meals, perform house cleaning, and supervise all residents.<br><br>ULP-B and ULP-E were hired on May 15, 2021, and October 1, 2020, respectively, to provide services under the comprehensive home care license and began providing assisted living services on August 1, 2021.<br><br>ULP-F was hired on June 12, 2022, to provide assisted living services to licensee's residents.<br><br>ULP-B, ULP-E, and ULP-F's employee records lacked orientation to assisted living requirements to include:<br>-an overview of chapter 144G.08 through 144G.93; and<br>-a review of the types of assisted living services the employee will be providing and the facility's category of licensure | 01460 | | |

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| 01460 | Continued From page 34<br><br>On July 10, 2024, at 11:00 a.m., licensed assisted living director (LALD)-A stated he did not have any training records in CNS-D's employee file but stated CNS-D completed orientation training at his other job unrelated to licensee.<br><br>On July 10, 2024, at 12:14 p.m., during phone interview, CNS-D stated he completed eight hours of dementia training in 2022, but he did not complete assisted living orientation or annual training.<br><br>The licensee's 5.01 Orientation of Staff and Supervisors and Content dated August 1, 2021, indicated all staff of [licensee] providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 01460 | | |
| 01500 SS=D | 144G.63 Subd. 5 Required annual training<br><br>(a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include:<br>(1) training on reporting of maltreatment of vulnerable adults under section 626.557;<br>(2) review of the assisted living bill of rights and staff responsibilities related to ensuring the | 01500 | | |

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| UNIVERSAL CARE HOMES LLC | 2301 16TH AVENUE SOUTH MINNEAPOLIS, MN 55404 |

| (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 |
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| 01500 | Continued From page 35<br><br>exercise and protection of those rights;<br>(3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases;<br>(4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders;<br>(5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and<br>(6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person.<br>(b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics:<br>(1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication;<br>(2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or<br>(3) information about strategies and technology | 01500 | | |

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| 01500 | Continued From page 36<br><br>that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure employees received at least eight (8) hours of training for each 12 months of employment for one of four employees (clinical nurse supervisor (CNS)-D).<br><br>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).<br><br>The findings include:<br><br>CNS-D was hired on October 1, 2020, to provide direct oversite to unlicensed personnel (ULP) and to provide direct care to residents.<br><br>CNS-D's employee record lacked required annual training.<br><br>On July 10, 2024, at approximately 11:15 a.m., licensed assisted living director (LALD)-A said staff completed some orientation and annual training on Educare (online training program) but said both CNS-D and registered nurse (RN)-C did not have accounts for Educare under the licensee. LALD-A stated both RN-C and CNS-D | 01500 | | |

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| 01500 | Continued From page 37<br><br>may have completed Educare courses for their other jobs unrelated to licensee. Surveyor requested those records.<br><br>On July 10, 2024, at 12:14 p.m., during phone interview, CNS-D stated he completed eight hours of dementia training in 2022, but he did not complete assisted living orientation or annual training.<br><br>The licensee's 5.06 Annual Required Staff Training policy dated August 1, 2021, read all staff that perform direct care services at [licensee] would complete at least eight (8) hours of annual training for each 12 months of employment.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 01500 | | |
| 01530 SS=E | 144G.64 TRAINING IN DEMENTIA CARE REQUIRED<br><br>(a) All assisted living facilities must meet the following training requirements:<br>(1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter;<br>(2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not | 01530 | | |

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| 01530 | Continued From page 38<br><br>provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter;<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview, and record review, the licensee failed to ensure direct-care staff received at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date for two of four direct care employees (unlicensed personnel (ULP)-B, ULP-F), licensee failed to ensure supervisors of direct-care staff received at least two hours of annual training for one of four employees (clinical nurse supervisor (CNS)-D).<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).<br><br>The findings include:<br><br>ULP-B | 01530 | | |

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| 01530 | Continued From page 39<br><br>ULP-B was hired May 15, 2021, under facility's comprehensive home care license. ULP-B began providing assisted living services on August 1, 2021.<br><br>ULP-B's training record included an Educare transcript (online training program) which indicated ULP-B completed four (4) hours of initial dementia training.<br><br>ULP-F<br>ULP-F was hired June 12, 2022, to provide direct care services to residents.<br><br>ULP-F's training record included an Educare transcript which indicated ULP-F completed three (3) hours of initial dementia training on July 3-4, 2022.<br><br>ULP-B and ULP-F's employee records lacked the required eight hours of dementia care training within 160 working hours of the employment start date.<br><br>CNS-D<br>CNS-D was hired on October 1, 2020, to provide direct supervision to unlicensed personnel and to provide direct care to residents.<br><br>CNS-D's employee record lacked two (2) hours of annual dementia training for years 2022 and 2023.<br><br>On July 10, 2024, at 12:14 p.m., CNS-D said he completed 8 hours of dementia training in 2022 (could not pinpoint exactly when) but did not complete any annual dementia training.<br><br>The licensee's 5.03 Dementia Training policy dated August 1, 2021, indicated supervisors of | 01530 | | |

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| 01530 | Continued From page 40<br><br>direct care staff would complete eight (8) hours of initial training within 120 hours of hire date and direct care employees would complete eight (8) hours of initial training within 160 hours of hire date. The policy also indicated all employees must complete two (2) hours of additional training for each 12 months of work thereafter.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 01530 | | |
| 01880 SS=F | 144G.71 Subd. 19 Storage of medications<br><br>An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure prescription medications were securely locked in a substantially constructed compartments and permitted only authorized personnel to have access.<br><br>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). | 01880 | | |

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| 01880 | Continued From page 41<br><br>The findings include:<br><br>On July 8, 2024, at 11:14 a.m., during entrance conference, registered nurse (RN)-C stated all resident medications were stored in a locked medication cabinet within the dining room off the kitchen.<br><br>On July 8, 2024, at 3:00 p.m., unlicensed personnel (ULP)-B pulled R1's medications and insulin in use from the medication cabinet to assist with insulin administration.<br><br>On July 9, 2024, at 12:33 p.m., surveyor observed R1's insulin stored unsecured within the left door of the kitchen fridge:<br>-Lantus SoloStar (insulin glargine) injection-six new insulin pens;<br>-Fiasp FlexTouch (insulin aspart injection)-two new insulin pens; and<br>-NovoLog FlexPen (insulin aspart) injection-three new insulin pens.<br><br>On July 9, 2024, at 12:50 p.m., the surveyor observed R3 obtain juice from the same fridge.<br><br>R1's Individualized Medication Management Plan signed by clinical nurse supervisor (CNS)-D on April 1, 2024, indicated R1's medications were stored in a locked cabinet in resident room and under "Notes" section, it indicated insulins were stored in fridge per manufacturer's recommendation. "The [resident] can self-administer insulin, ULP will only set up the insulins."<br><br>On July 9, 2024, at 2:22 p.m., CNS-D stated he didn't realize insulins would also need to be locked up if other medications were. | 01880 | | |

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| 01880 | Continued From page 42<br><br>On July 10, 2024, at 12:00 p.m., licensed assisted living director (LALD)-A stated they had used a lockable metal container for R1's insulins prior to R1's discharge. When R1 re-admitted, they did not return to using the metal container. LALD-A stated when they located the metal container, they would start utilizing it for R1's insulins.<br><br>The licensee's 7.11 Medication Storage policy dated August 1, 2021, indicated medications would be stored consistent with each resident's medication management plan and service plan. Medications managed by [licensee] would be stored to prevent diversion of medications by residents or others who may have access to the medications. Medications managed outside of a resident's private "living space" must be in securely locked and substantially constructed compartments and permit only authorized personnel to have access. They may be a medication room, medication cart, or similar set up.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01880 | | |
| 01940 SS=D | 144G.72 Subd. 3 Individualized treatment or therapy managemen<br><br>For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility | 01940 | | |

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| 01940 | Continued From page 43<br><br>must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following:<br>(1) a statement of the type of services that will be provided;<br>(2) documentation of specific resident instructions relating to the treatments or therapy administration;<br>(3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel;<br>(4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and<br>(5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to develop and implement an individual treatment or therapy management plan (ITTMP) to include all required content for one of one resident (R1) receiving assistance with blood glucose checks.<br><br>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 | 01940 | | |

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| 01940 | Continued From page 44<br><br>limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).<br><br>The findings include:<br><br>R1's diagnosis included type 2 diabetes and schizophrenia.<br><br>R1's service plan signed April 1, 2024, indicated unlicensed personnel (ULP) to assist with treatments/therapies per medication administration record. The service plan did not specify which treatments and/or therapies.<br><br>R1's unsigned after visit summary (AVS) dated July 5, 2024, indicated to check blood glucose three times a day (TID).<br><br>On July 8, 2024, at 2:55 p.m., surveyor observed ULP-B provide blood glucose equipment to R1 to self-check her blood glucose and R1 provided ULP-B the result. At 3:00 p.m., ULP-B set up R1's insulin for R1 to self-administer.<br><br>R1's "blood glucose log" dated July 1-9, 2024, included documentation of blood glucose results under columns titled "Pre-breakfast, pre-lunch, and pre-bedtime." The log also included blood glucose results under columns titled "post-breakfast and post-lunch," on July 4, 5, and 6, 2024.<br><br>R1's medical record lacked an ITTMP to include the following content regarding blood glucose checks:<br>-a statement of the type of services that will be provided;<br>-documentation of specific resident instructions relating to the treatments or therapy | 01940 | | |

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| 01940 | Continued From page 45<br><br>administration; and<br>-any resident-specific requirements relating to documentation of treatment and therapy received.<br><br>On July 9, 2024, at 2:22 p.m., clinical nurse supervisor (CNS)-D reviewed R1's current service plan and he indicated the service plan did not specify what treatment would be provided by licensee. CNS-D also indicated the "blood glucose log" did not have specific times when R1's blood glucose checks should be performed.<br><br>The licensee's 7.15 Medication & Treatment-Administration & Delegation policy dated August 1, 2021, indicated licensee would do the following:<br>-prepare and include in the service plan a written statement of the medication management or treatment/therapy services that would be provided to the resident;<br>-an RN must specify, in writing, specific instructions for each resident and document those instructions in the resident's record.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01940 | | |
| 01960 SS=D | 144G.72 Subd. 5 Documentation of administration of treatments<br><br>Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as | 01960 | | |

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| 01960 | Continued From page 46<br><br>ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure treatment or therapy services were documented for one of one resident (R1) receiving blood glucose checks.<br><br>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).<br><br>The findings include:<br><br>R1's diagnosis included diabetes type 2 and schizophrenia.<br><br>R1's service plan signed April 1, 2024, indicated unlicensed personnel (ULP) to assist with treatments/therapies per medication administration record. The service plan did not specific which treatments and/or therapies.<br><br>R1's unsigned after visit summary (AVS) dated July 5, 2024, indicated to check blood glucose three times a day (TID).<br><br>On July 8, 2024, at 2:55 p.m., surveyor observed ULP-B provide R1 to self-check her blood glucose and provided ULP-B the result. At 3:00 | 01960 | | |

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|---|---|---|---|---|
| 01960 | Continued From page 47<br><br>p.m., ULP-B set up R1's insulin for R1 to self-administer.<br><br>R1's "blood glucose log" dated July 1-9, 2024, included documentation of blood glucose results under columns titled "Pre-breakfast, pre-lunch, and pre-bedtime." The log also included blood glucose results under columns titled "post-breakfast and post-lunch," on July 4, 5, and 6, 2024.<br><br>On July 9, 2024, at 2:22 p.m. clinical nurse supervisor (CNS)-D stated the blood glucose log did not contain the correct time, name, and title of the person documenting the blood glucose results.<br><br>The licensee's 7.22 Medication & Treatment Record-Documentation & Refusal policy dated August 1, 2021, indicated licensee would create and maintain a correct and accurate medication and/or treatment/therapy record for each resident receiving those services. The policy also indicated the following must be documented in the resident's medication and/or treatment/therapy records after providing medication assistance or administration:<br>-date;<br>-time;<br>-quantity of dosage;<br>-method of administration of all prescribed legend and over-the-counter medications and or treatment/therapy; and<br>-signature and title of the authorized person who provided the assistance and/or administration of medications/treatment/therapy.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) | 01960 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 36721 | A. BUILDING: _____ B. WING _____ | 07/12/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| UNIVERSAL CARE HOMES LLC | 2301 16TH AVENUE SOUTH MINNEAPOLIS, MN 55404 |

| (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 |
|---|---|---|---|---|
| 01960 | Continued From page 48<br>days | 01960 | | |

Minnesota Department of Health
Environmental Health, FPLS
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *07/09/24*
Time: 09:45:00
Report: 1039241195

# Food and Beverage Establishment Inspection Report



**Location:**
Universal Care Homes Llc
2301 16th Avenue South
Minneapolis, MN55404
Hennepin County, 27

**Establishment Info:**
ID #: 0039054
Risk:
Announced Inspection: No

**License Categories:**

Expires on: / /

**Operator:**

Phone #: 6127019073
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.

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

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

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

SHELL EGGS STORED ABOVE READY-TO-EAT FOODS IN REFRIGERATOR. INSTRUCTED PERSON-IN-CHARGE TO SEPARATE SO EGGS CANNOT CONTAMINATE OTHER FOODS IF BROKEN. STACKING ORDER GUIDANCE DOCUMENT SENT WITH REPORT.

*Comply By: 07/09/24*

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

***3-501.17B*** ***** Priority 2 *****

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

MILK JUG OPENED MORE THAN 24 HOURS LACKS A DATE MARK. COMPLY WITH ABOVE. GUIDANCE DOCUMENT ON TOPIC SENT WITH REPORT.

*Comply By: 07/09/24*

**4-600 Cleaning Equipment and Utensils**

***4-601.11C***

MN Rule 4626.0840C Clean non-food contact surfaces of equipment and maintain free of accumulations of dust, dirt, food residue, and other debris.

KITCHEN CUPBOARD SURFACES HAVE ACCUMULATED SOILS. COMPLY WITH ABOVE.

*Comply By: 07/09/24*

**6-300 Physical Facility Numbers and Capacities**

***6-301.14A***

MN Rule 4626.1457 Provide a sign or poster at all handwashing sinks used by food employees that notifies them to wash their hands

SINK COMPARTMENT DESIGNATED FOR HANDWASHING LACKS A REMINDER SIGN. COMPLY WITH ABOVE.

*Comply By: 07/09/24*

**Food and Equipment Temperatures**

Process/Item: MILK
Temperature: 41 Degrees Fahrenheit - Location: COLD HOLD IN REFRIGERATOR
Violation Issued: No

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

The inspection was completed with the persons-in-charge and reviewed with MDH nurse evaluator Anna Bohnen.

No food preparation occurred during the inspection.

The kitchen is of residential build and should serve food for same-day service only.

The kitchen has wood cabinets with hollow base, laminate floor, painted walls and ceiling and laminate countertops. The kitchen surfaces and finishes are clean and well maintained.

The kitchen refrigerator/freezer is of residential grade.

A 2-compartment sink is present in kitchen. 1 compartment is designated for handwashing only.

A residential dishwashing machine is present in the kitchen. Per thermopaper test and utensil surface temperature thermometer test done by kitchen staff, the dishwashing machine achieves a sanitizing rinse temperature greater than 160 degrees F.

A supply of single-use gloves is present in kitchen. A thin-probe food thermometer is present in kitchen. A supply of single-use sanitizing wipes for food contact surfaces is present in kitchen. Staff may also wish to prepare a sanitizing solution by mixing 1 tablespoon of unscented concentrated bleach with 1 gallon of water. This solution may be used to sanitize countertops, sinks and other food contact surfaces as long as it is between 50 - 200 ppm Chlorine, judged by Chlorine test strips.

Discussed the following with the person-in-charge: minimum cook temps for animal proteins, food source, foodborne illness symptoms and exclusion of ill employees, avoiding bare hand contact with ready to eat foods, handwashing, sanitizing.

Type: Full
Date: *07/09/24*
Time: 09:45:00
Report: 1039241195
Universal Care Homes Llc

# Food and Beverage Establishment Inspection Report

**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 1039241195 of 07/09/24.

Certified Food Protection Manager: Yasir Ali

Certification Number: FM122372 Expires: 03/01/27

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

Signed: _____
Yasir Ali
manager

Signed: _____
Aron Goodner
Public Health Sanitarian I
Freeman Building
aron.goodner@state.mn.us