DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

February 24, 2023

Licensee
Unique Homes LLC
3940 46th Avenue North
Robbinsdale, MN 55422

RE: Project Number(s) SL37197015

Dear Licensee:

On February 9, 2023, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine if orders from the July 14, 2022, evaluation were corrected. This follow-up evaluation verified that the facility is in substantial compliance.

It is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body. You are encouraged to retain this document for your records.

Please feel free to call me with any questions.

Sincerely,

Jessica Chenze, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: jessica.chenze@state.mn.us
Telephone: 218-332-5175 | Fax: 218-332-5196

HHH

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

January 3, 2023

Licensee
Unique Homes, LLC
3940 46th Avenue North
Robbinsdale, MN 55422

RE: Project Number(s) SL37197015

Dear Licensee:

On December 2, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine correction of orders found on the evaluation completed on July 14, 2022. This follow-up evaluation determined your facility had not corrected all of the state licensing orders issued pursuant to the July 14, 2022 evaluation.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state licensing orders issued pursuant to the last evaluation completed on July 14, 2022, found not corrected at the time of the December 2, 2022, follow-up evaluation and/or subject to penalty assessment are as follows:

0250-Conditions-144g.20 Subdivision 1 = $500
0680-Disaster Planning And Emergency Preparedness-144g.42 Subd. 10 = $500
0800-Fire Protection And Physical Environment-144g.45 Subd. 2 (a) (4) = 500
0970-Waivers Of Liability Prohibited-144.50 Subd. 5 = $500
1530-Training In Dementia Care Required-144g.64 = $500
1790-Medication Management For Residents Who Will-144g.71 Subd. 10 = $500

The details of the violations noted at the time of this follow-up evaluation completed on December 2, 2022 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Also, at the time of this follow-up evaluation completed on December 2, 2022, we identified the following violation(s):

1290-Background Studies Required-144g.60 Subdivision 1 = $3,000

The details of the violation(s) noted at the time of this follow-up evaluation are delineated on the attached State Form. Only the ID Prefix Tag in the left hand column without brackets will identify these licensing orders. It is not necessary to develop a plan of correction.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $6,000**. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), by the correction order date, the licensee must document in the provider's records any action taken to comply with the correction order by the correction order date. The commissioner may request a copy of this documentation and the assisted living facility's action to respond to the correction orders in future evaluations, upon a complaint investigation, and as otherwise needed.

IMPOSITION OF FINES:

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.

CORRECTION ORDER RECONSIDERATION PROCESS
In accordance with Minn. Stat. § 144G.32, Subd. 2, you have one opportunity to challenge the correction order issued, including the level and scope, and any fine assessed through the correction order reconsideration process. This written request must be received by the Department of Health within 15 calendar days of the correction order receipt date. Please send your written request via email to the following:

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

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. Requests for hearing may be emailed to **Health.HRD.Appeals@state.mn.us**.

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both.

We urge you to review these orders carefully. If you have questions, please contact Casey DeVries at 651-201-5917.

Please note, it is your responsibility to share the information contained in this letter and the results of

this visit with the President of your facility's Governing Body.

Sincerely,

Casey DeVries, Supervisor
State Evaluation Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-201-5917 Fax: 651-215-9697

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37197	A. BUILDING: _____ B. WING _____	R 12/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIQUE HOMES LLC	3940 46TH AVENUE NORTH ROBBINSDALE, MN 55422

(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 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: SL37197015-2 On December 1, 2022, through December 2, 2022, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a licensing order follow up survey completed on September 7, 2022. At the time of the survey, there were five residents receiving services under the Assisted Living license. As a result of the revisit, the following orders were reissued and/or issued. An immediate correction order was identified on December 2, 2022, issued for SL37197015-2, tag identification 1290. On December 2, 2022, the immediacy of correction order 1290 was removed, however, non-compliance remained at a level 3, widespread scope of violation.	{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.	

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{0 250} SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under	{0 250}		

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{0 250}	Continued From page 2 section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to show they met the requirements of licensure, by attesting the managerial officials who oversaw the day-to-day operations understood applicable statutes and rules; nor developed and/or implemented current policies and procedures as required with records reviewed. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is 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 December 1, 2022, through December 2, 2022, the Minnesota Department of Health	{0 250}		

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{0 250}	Continued From page 3 conducted a revisit at the above provider to follow-up on orders issued pursuant to a follow-up survey completed on September 7, 2022. The original survey was completed July 14, 2022. During the entrance conference for the survey on July 12, 2022, at approximately 10:37 a.m., licensed assisted living director (LALD)-A stated the licensee's employees in charge of the facility were familiar with the assisted living regulations and the licensee provided medication and treatment management services. The licensee's Application for Assisted Living License, section titled Official Verification of Owner or Authorized Agent, (page four and five of the application), identified, I certify I have read and understand the following: [a check mark was placed before each of the following]: - I have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section] 144G.45, my building(s) must comply with subdivisions 1-3 of the section, as applicable section Laws 2020, 7th Spec. [special] Sess [session]., chpt. [chapter] 1. art. [article] 6, sect. 17. - I have read and fully understand Minn. Stat. sect. 144G.80, 144G.81. and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22, my building(s) must comply with these sections if applicable. - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G. - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659.	{0 250}		

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{0 250}	Continued From page 4 - Reporting of Maltreatment of Vulnerable Adults. - Electronic Monitoring in Certain Facilities. - I understand pursuant to Minn. Stat. sect. 13.04 Rights of Subjects of Data, the Commissioner will use information provided in this application, which may include an in-person or telephone conference, to determine if the applicant meets requirements for assisted living licensing. I understand I am not legally required to supply the requested information; however, failure to provide information or the submission of false or misleading information may delay the processing of my application or may be grounds for denying a license. I understand that information submitted to the commissioner in this application may, in some circumstances, be disclosed to the appropriate state, federal or local agency and law enforcement office to enhance investigative or enforcement efforts or further a public health protective process. Types of offices include Adult Protective Services, offices of the ombudsmen, health-licensing boards, Department of Human Services, county or city attorneys' offices, police, local or county public health offices. - I understand in accordance with Minn. Stat. sect. 144.051 Data Relating to Licensed and Registered Persons (opens in a new window), all data submitted on this application shall be classified as public information upon issuance of a provisional license or license. All data submitted are considered private until MDH issues a license. - I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659 governing the provision of assisted living facilities, and	{0 250}		

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{0 250}	Continued From page 5	{0 250}		

understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract.

- I have examined this application and all attachments and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct, and complete. I will notify MDH, in writing, of any changes to this information as required.

- I attest to have all required policies and procedures of Minn. Stat. chapter 144G and Minn. Rules chapter 4659 in place upon licensure and to keep them current as applicable.

Page five was electronically signed by licensed assisted living director/owner (LALD)-A on May 24, 2021.

The licensee had an assisted living license issued on August 1, 2022, with an expiration date of June 30, 2022.

The licensee failed to ensure the following policies and procedures were developed and/or implemented:
(1) orientation, training, and competency evaluations of staff, and a process for evaluating staff performance;
(2) handling complaints regarding staff or services provided by staff;
(3) medication management;
(4) conducting employee background studies
(5) disaster planning and emergency

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{0 250}	Continued From page 6 preparedness (6) assisted living contract requirements; and As a result of this survey, the following orders were re-issued: 0250, 0680, 0800, 0930, 0940, 0970, and a new correction order was issued for 1290, indicating the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.08 to 144G.95. No further information was provided.	{0 250}		
{0 680} SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant 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	{0 680}		

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{0 680}	Continued From page 7 working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop a written emergency preparedness plan with all the required content. This had the potential to affect all five current residents, staff, and any visitors to 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) 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 December 1, 2022, at 10:33 a.m., the surveyor asked licensed assisted living director (LALD)-C and program manager (PM)-E what updates to the licensee's emergency preparedness (EP) plan were made since the follow-up survey this past September. LALD-C gave the surveyor their "Emergency Preparedness Manual," which the surveyor recalled from the prior surveys and asked again what had been updated in the EP plan. PM-E said they had completed some training with staff and residents. The surveyor requested documentation of the training. The surveyor reviewed The licensee's Emergency Preparedness Manual. The fourth page of the binder contained a signature page, with a place to	{0 680}		

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{0 680}	Continued From page 8 document the date of review of the plan; it was blank. The manual contained documents, forms, and information about emergency preparedness (EP) planning. There were numerous forms/checklists including: a hazard-vulnerability assessment tool (which was not completed or dated), a communication plan template, phone number list, location of fire extinguisher drawing, emergency information for resident, fire drill log and audit tool. The manual contained policies for fire safety, missing resident, and a general EP policy. The licensee lacked an emergency preparedness plan to address the following requirements: -current, all-hazards approach facility assessment; -description of the population served by licensee; -process for emergency preparedness (EP) cooperation with state and local EP officials/organizations; -subsistence needs for staff and residents during emergency situation; -procedure for tracking staff and residents; -development of all policies/procedures, based on assessment; and additional policies for: -potential evacuation; -sheltering in place; -handling medical documents; -handling and use of volunteers; -arrangement with other faculties (including sister facilities); -development of a communication plan, including primary and alternate means for communication; -methods for sharing information; -EP training and testing program; -EP training program for staff (including documentation of training provided); and -annual EP testing requirements.	{0 680}		

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{0 680}	Continued From page 9 The licensee's EP plan lacked evidence the plan was updated or revised since the prior survey exit date of September 7, 2022. On December 1, 2022, at 2:18 p.m., registered nurse (RN)-B reviewed the EP plan and stated they could see it was not updated. RN-B said they would have to learn from this survey, move forward and complete what needs to be done. The licensee's 9.0 Emergency Preparedness Plan - Appendix Z Compliance policy, undated, indicated it is the intent the licensee has in place an effective and compliant emergency preparedness plan that is aligned with Appendix Z (the state-adopted tool for emergency plan development). The plan would include four primary components: risk assessment and planning; policies and procedures; a communication plan and staff training and exercises/drills. No further information was provided.	{0 680}		
{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 facility's physical	{0 800}		

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{0 800}	Continued From page 10	{0 800}		

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.

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 residents).

The findings include:

On December 01, 2022, from approximately 12:30 p.m. to 1:30 p.m., survey staff toured the facility with the licensed assisted living director (LALD)-C and the program director (PD)-F. During the facility tour, survey staff observed the following:

1. The garage floor had a large crack in the concrete running the width of the garage.

2. The storage room beneath the garage had a matching crack in the ceiling with signs of water damage. The ceiling was sagging in the middle and had some discoloration and dark staining on the ceiling material. There were small portions of the concrete plank missing from the ceiling all along the damaged area. The room smelled strongly of a wet, musty basement and everything was covered in spider webs and cobwebs. The concrete floor was stained in the shape of ponding water or other liquid near the foundation wall. Nothing had been done to address the damaged insulation along the wall.

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UNIQUE HOMES LLC	3940 46TH AVENUE NORTH ROBBINSDALE, MN 55422

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{0 800}	Continued From page 11 LALD-C and PD-F verbally confirmed survey staff observations during the facility tour. LALD-C stated they were having difficulty working with the landlord to fix the garage floor. No further information was provided.	{0 800}		
{0 930} SS=C	144G.50 Subd. 2 (d-e; 1-4) Contract information (d) The contract must include a description of the facility's complaint resolution process available to residents, including the name and contact information of the person representing the facility who is designated to handle and resolve complaints. (e) The contract must include a clear and conspicuous notice of: (1) the right under section 144G.54 to appeal the termination of an assisted living contract; (2) the facility's policy regarding transfer of residents within the facility, under what circumstances a transfer may occur, and the circumstances under which resident consent is required for a transfer; (3) contact information for the Office of Ombudsman for Long-Term Care, the Ombudsman for Mental Health and Developmental Disabilities, and the Office of Health Facility Complaints; (4) the resident's right to obtain services from an unaffiliated service provider; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to execute a written assisted living contract with required content for three of three residents (R1, R2, R5).	{0 930}		

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{0 930}	Continued From page 12 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). The findings include: R1, R2, and R5's assisted living contracts lacked description of the licensee's name and contact information of the person at the facility in charge of complaints. R1 R1 was admitted for services July 2, 2022. On December 1, 2022, at approximately 9:11 a.m., the surveyor observed unlicensed personnel (ULP)-A administer medications to R1. R1's Resident Contract for Assisted Living, signed by R1 on July 2, 2022, lacked the content detailed above. R2 R2 was admitted for services June 2, 2022. On December 1, 2022, at approximately 8:55 a.m., the surveyor observed unlicensed personnel (ULP)-A administer medications to R2. R2's Resident Contract for Assisted Living, signed by R2 on June 20, 2022, lacked the content detailed above. R5 R5 was admitted for services October 13, 2022.	{0 930}		

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{0 930}	Continued From page 13 R5's Resident Contract for Assisted Living, signed by R5 on October 13, 2022, lacked the content detailed above. On December 1, 2022, at 10:36 a.m., program manager (PM)-E stated they made a new contract, and all residents were to get the updated version, but none of them did. The licensee's 1.05 Signing an Assisted Living Contract policy, undated, indicated when a prospective resident decides to move into the facility, it requires an assisted living contract signed and received by the facility. The policy did not address the content of the contract. No further information was provided.	{0 930}		
{0 940} SS=C	144G.50 Subd. 2 (e; 5-7) Contract information (5) a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including: (i) whether the facility is enrolled with the commissioner of human services to provide customized living services under medical assistance waivers; (ii) whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b); (iii) whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided; (iv) whether the facility requires a resident to pay privately for a period of time prior to accepting	{0 940}		

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{0 940}	Continued From page 14 payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required; (v) a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent; (vi) a statement that residents may be eligible for assistance with rent through the housing support program; and (vii) a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program; (6) the contact information to obtain long-term care consulting services under section 256B.0911; and (7) the toll-free phone number for the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to execute a written assisted living contract with the required content for three of three residents (R1, R2, R5). 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). The findings include: R1, R2, and R5's assisted living contracts lacked the following content: -a description of the facility's policies related to	{0 940}		

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{0 940}	Continued From page 15 medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including: -whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided; -whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required; -a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent; -a statement that residents may be eligible for assistance with rent through the housing support program; -a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program; and -the contact information to obtain long-term care consulting services under section 256B.0911. R1 R1 was admitted for services July 2, 2022. On December 1, 2022, at approximately 9:11 a.m., the surveyor observed unlicensed personnel (ULP)-A administer medications to R1. R1's Resident Contract for Assisted Living was signed by R1 on July 2, 2022, and lacked the content described above. R2 R2 was admitted for services June 2, 2022.	{0 940}		

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{0 940}	Continued From page 16 On December 1, 2022, at approximately 8:55 a.m., the surveyor observed unlicensed personnel (ULP)-A administer medications to R2. R2's Resident Contract for Assisted Living, signed by R2 on June 20, 2022, and lacked the content described above. R5 R5 was admitted for services October 13, 2022. R5's Resident Contract for Assisted Living, signed by R5 on October 13, 2022, and lacked the content described above. On December 1, 2022, at 10:36 a.m., program manager (PM)-E stated they made a new contract, and all residents were to get the updated version, but none of them did. The licensee's 1.05 Signing an Assisted Living Contract policy, undated, indicated when a prospective resident decides to move into the facility, it requires an assisted living contract signed and received by the facility. The policy did not address the content of the contract. No further information was provided.	{0 940}		
{0 970} SS=F	144.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is	{0 970}		

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{0 970}	Continued From page 17 required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the facility's liability for health, safety, or personal property of a resident for three of three residents (R1, R2, R5). This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee provided the surveyor with a copy of their updated agreement, "Resident Contract for Assisted Living," undated. Although the updated version did not include waivers of resident liability, neither R1, R2 nor R5 signed the licensee's updated contract, but rather each had the older version. R1, R2, and R5's assisted living contracts included waivers of facility liability. R1 R1 was admitted for services and signed the licensee's assisted living contract on July 2, 2022. R2 R2 was admitted for services and signed the licensee's assisted living contract on June 2, 2022.	{0 970}		

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{0 970}	Continued From page 18	{0 970}		

R5
R5 was admitted for services and signed the licensee's assisted living contract on October 13, 2022.

The assisted living contracts included two clauses that indicated the resident would waive the facility's liability for health, safety, or personal property of a resident. Page 15, section 27 titled "Indemnification," the contract indicated: Resident will indemnify and hold harmless landlord, its employees and agents from and against any and all claims, actions, damages and liability and expense in connection with loss of life, personal injury or damage to property, arising from or out of the use by resident of the rented premises or any other part of the landlord's property, or caused wholly or in part by an act or omission of resident or resident's guests or agents.

On page 16 of the contract, in the section titled "Liability," the contract indicated: Landlord is not liable to resident or resident's guests for any injury, death or property damage occurring in room or on provider's premises unless such injury, death or property damage occurs as a result of an equipment malfunction or hazardous condition within the building not caused by resident or resident's guests. Landlord is also not liable for any injury, death or damage occurring as the result of resident's receipt of health-related, supporting or other services from third part providers. Landlord may be liable to resident for its own negligent acts of those of its employee or agents. Unless caused by one of the aforementioned excepted reasons, resident agrees to hold landlord harmless from any and all claims for injuries, property damage or any other loss resulting from and accident or other

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{0 970}	Continued From page 19 occurrence in the room or on landlord's premises. On December 1, 2022, at 10:36 a.m., program manager (PM)-E stated they made a new contract, and all residents were to get the updated version, but none of them did. PM-E did not realize the new version of the contract was not in compliance, adding all residents were to get an updated version. The licensee's 1.05 Signing an Assisted Living Contract policy, undated, indicated when a prospective resident decides to move into the facility, it requires an assisted living contract signed and received by the facility. The policy did not address the content of the contract. No further information was provided.	{0 970}		
01290 SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced	01290		

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01290	Continued From page 20 by: Based on observation, interview, and record review, the licensee failed to ensure a background study was completed as required for two of two employees (unlicensed personal (ULP)-A and ULP-B). 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). This resulted in an immediate order for correction on December 2, 2022. The findings include: ULP-A ULP-A was hired on September 1, 2022, to provide assisted living services to the licensee's residents. On December 1, 2022, at 8:55 a.m., the surveyor observed ULP-A administer medications to R4. On December 1, 2022, at 10:57 a.m., the surveyor requested ULP-A's employee file. Program manager (PM)-E said they did not have ULP-A's employee file in house, that the former registered nurse had the employee's file because the nurse was completing some training with ULP-A. There was no way to verify ULP-A had a current background study and was cleared to provide services for the licensee.	01290	On December 2, 2022, the immediacy of correction order 1290 was removed, however, non-compliance remained at a level 3, widespread scope of violation.	

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01290	Continued From page 21 ULP-B ULP- was hired November 1, 2022, to provide assisted living services to the licensee's residents. On December 1, 2022, at 8:35 a.m., the surveyor met ULP-B who stated he was a resident assistant, that he just completed working the overnight shift from 11:00 p.m. to 7:00 a.m., and was waiting for his ride home. On December 1, 2022, at 11:25 a.m., program manager (PM)-E told the surveyor ULP-B's file was not available as the employee only worked intermittently and he did not have his file here. There was no way to verify ULP-B had a current background study and was cleared to provide services for the licensee. On December 2, 2022, at 11:18 a.m., a search of Department of Human Services (DHS) NetStudy website indicated there were no completed or licensee-affiliated background studies for either ULP-A or ULP-B. On December 2, 2022, at 11:48 a.m., the surveyor spoke with licensed assisted living director (LALD)-C and again requested employee files for ULP-A and ULP-B. The surveyor requested the files be sent within the next two hours or by 2:00 p.m. The surveyor told LALD-C neither ULP-A nor ULP-B's background study could be verified as submitted, cleared, or affiliated with the licensee. The surveyor informed LALD-C if there was no evidence of completed background studies, the licensee would receive an immediate order related to lack of background studies for ULP-A and ULP-B. LALD-C said he was aware this could be a problem and said he would send the requested files to the surveyor.	01290		

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01290	Continued From page 22 LALD-C said he could not confirm whether ULP-A or ULP-B had background studies done and said if there was nothing in the file, it may mean the employees had to do finger printing and we [the licensee] did not follow up on the finger printing. A review of a screenshot of the licensee's staff roster on the DHS NetStudy website, dated December 2, 2022, at 2:31 p.m., indicated ULP-A was not listed on the roster. A subsequent screenshot of the roster at 2:45 p.m., indicated ULP-A was on the roster and listed the affiliation date as December 2, 2022, today's date, indicating the licensee submitted the background study for ULP-A after the surveyor informed the licensee of the findings. The roster indicated ULP-A's status, whether the employee is eligible to provide services, as "in process". ULP-B was not on the roster in either screenshot. The licensee's Personnel Records policy dated August 1, 2021, indicated each employee record would include documentation of a completed background study. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	01290		
{01530} SS=F	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (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	{01530}		

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{01530}	Continued From page 23 related to dementia care for each 12 months of employment thereafter; (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 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; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure staff received required dementia care training in the required time frame for one of three employees, (program manager (PM)-E). 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:	{01530}		

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{01530}	Continued From page 24 Program manager (PM)-E was hired November 16, 2020, to provide direct care services to the licensee's residents. PM-E's employee record indicated the employee did not complete eight required hours of training in dementia care within 120 hours of the employee's start date. The record indicate PM-E had 0 hours of dementia training. On December 1, 2022, at 1:45 p.m., registered nurse (RN)-D said the training was kind of "messed up," including the missed dementia care training for PM-E. RN-D said staff were to have at least the minimum required dementia training. The licensee's 5.03 Dementia Training policy, undated, indicated all staff are required to complete dementia training at the time of hire and annually thereafter. The policy indicated supervisors of direct care stall will complete eight hours of initial training within 120 of employment start date; and direct care staff will complete eight hours within 160 hours of employment start date. No further information was provided.	{01530}		
{01790} SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the	{01790}		

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	37197	A. BUILDING: _____ B. WING _____	R 12/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIQUE HOMES LLC	3940 46TH AVENUE NORTH ROBBINSDALE, MN 55422

(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
{01790}	Continued From page 25	{01790}		

medications, including controlled substances; and
(4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled.
(b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if:
(1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and
(2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address:
(i) the type of container or containers to be used for the medications appropriate to the provider's medication system;
(ii) how the container or containers must be labeled;
(iii) written information about the medications to be provided;
(iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information;
(v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative;

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{01790}	Continued From page 26 (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) developed written procedures for the unlicensed personnel (ULP) providing medications to residents having unplanned time away when the licensed nurse was not available. This had the potential to affect all five residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee's 7.10 Medication Management - Planned & Unplanned Time Away policy, undated, indicated for unplanned resident time away when a pharmacist or licensed nurse was not available, the RN could delegate this task to ULP if the RN had developed written procedures for the ULP including any special instructions or procedures regarding controlled substances that were	{01790}		

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{01790}	Continued From page 27	{01790}		

prescribed for the resident. The written procedure must address:
- the type of container or containers to be used for the medications appropriate to the provider's medication system;
- how the container or containers must be labeled;
- written information about the medications to be provided;
- how the ULP must document in the resident's record that medications have been provided, including documenting the date the medications where provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information;
- how the RN would be notified that medications have been provided and whether the RN needs to be contacted before the medications are given to the resident or the designated representative;
- a review by the RN of the completion of this task to verify that this task was completed accurately by the ULP; and
- how the ULP must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each medication returned.

On December 1, 2022, at 11:33 a.m., program manager (PM)-E said the former RN (registered nurse) left a short time ago, and was supposed to have completed this, but PM-E was not sure if that had been done. PM-E stated they thought there was a form staff were to use when this [resident unplanned time away] happened. The surveyor requested the form. The current nurse, RN-D, said she was not familiar with the survey corrections that were made but it looked like this

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{01790}	Continued From page 28 procedure was not done. No further information was provided.	{01790}		

Electronically delivered

September 27, 2022

Administrator
Unique Homes, LLC
3940 46th Avenue North
Robbinsdale, MN 55422

RE: Project Number(s) SL37197015

Dear Administrator:

On September 7, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine correction of orders found on the evaluation completed on July 14, 2022. This follow-up evaluation determined your facility had not corrected all of the state licensing orders issued pursuant to the July 14, 2022 evaluation.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state licensing orders issued pursuant to the last evaluation completed on July 14, 2022, found not corrected at the time of the September 7, 2022, follow-up evaluation and/or subject to penalty assessment are as follows:

0250-Conditions-144g.20 Subdivision 1 = $500
0480-Minimum Requirements-144g.41 Subd 1 (13) (i) (b) = $500
0490-Minimum Requirements-144g.41 Subd 1 (13) (ii)-(vii) = $500
0680-Disaster Planning And Emergency Preparedness-144g.42 Subd. 10 = $500
0780-Fire Protection And Physical Environment-144g.45 Subd. 2 (a) (1) = $500
0790-Fire Protection And Physical Environment-144g.45 Subd. 2 (a) (2)-(3) = $500
0800-Fire Protection And Physical Environment-144g.45 Subd. 2 (a) (4) = $500
0810-Fire Protection And Physical Environment-144g.45 Subd. 2 (b)-(f) = $500
0970-Waivers Of Liability Prohibited-144g.50 Subd. 5 = $500
1460-Orientation Of Staff And Supervisors-144g.63 Subdivision 1 = $500
1530-Training In Dementia Care Required-144g.64 = $500
1790-Medication Management For Residents Who Will-144g.71 Subd. 10 = $500

The details of the violations noted at the time of this follow-up evaluation completed on September 7, 2022 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $6,000**. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

Also, at the time of this follow-up evaluation completed on September 7, 2022, we identified the

following violation(s):

1750-Delegation Of Medication Administration-144g.71 Subd. 7

The details of the violation(s) noted at the time of this follow-up evaluation are delineated on the attached State Form. Only the ID Prefix Tag in the left hand column without brackets will identify these licensing orders. It is not necessary to develop a plan of correction.

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), by the correction order date, the licensee must document in the provider's records any action taken to comply with the correction order by the correction order date. The commissioner may request a copy of this documentation and the assisted living facility's action to respond to the correction orders in future evaluations, upon a complaint investigation, and as otherwise needed.

IMPOSITION OF FINES:

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.

CORRECTION ORDER RECONSIDERATION PROCESS
In accordance with Minn. Stat. § 144G.32, Subd. 2, you have one opportunity to challenge the correction order issued, including the level and scope, and any fine assessed through the correction order reconsideration process. This written request must be received by the Department of Health within 15 calendar days of the correction order receipt date. Please send your written request via email to the following:

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

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

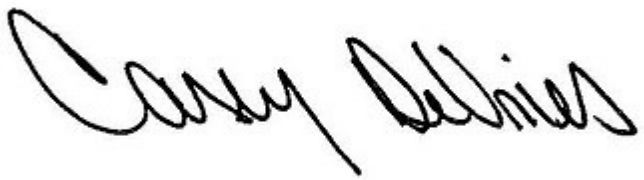
hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. Requests for hearing may be emailed to **Health.HRD.Appeals@state.mn.us**.

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both.

We urge you to review these orders carefully. If you have questions, please contact Casey DeVries at 651-201-5917.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Sincerely,



Casey DeVries, Supervisor
State Evaluation Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-201-5917 Fax: 651-215-9697

PMB

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{0 000}	Initial Comments 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: SL37197015-1 On September 6, 2022, through September 7, 2022, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on July 14, 2022. At the time of the survey, there were four residents, all of whom were receiving services under the Assisted Living license. As a result of the revisit, the following orders were reissued and/or issued.	{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 144A.474 subd. 11 (b) (1) (2) -or- 144G.31 subd. 1, 2 and 3	

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{0 000}	Continued From page 1	{0 000}		

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{0 000}	Continued From page 2	{0 000}		

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{0 000}	Continued From page 3	{0 000}		

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{0 000}	Continued From page 4	{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.	

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{0 000}	Continued From page 5	{0 000}	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. 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	

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{0 000}	Continued From page 6	{0 000}	tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
{0 250} SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection,	{0 250}		

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{0 250}	Continued From page 7 survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to show they met the requirements of licensure, by attesting the managerial officials who oversaw the day-to-day operations understood applicable statutes and rules; nor developed and/or implemented current policies and procedures as required with records reviewed. This had the potential to affect all residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is 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).	{0 250}		

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{0 250}	Continued From page 8 The findings include: On September 6, 2022, through September 7, 2022, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on July 14, 2022. During the entrance conference for the survey on July 12, 2022, at approximately 10:37 a.m., licensed assisted living director (LALD)-A stated the licensee's employees in charge of the facility were familiar with the assisted living regulations and the licensee provided medication and treatment management services. The licensee's Application for Assisted Living License, section titled Official Verification of Owner or Authorized Agent, (page four and five of the application), identified, I certify I have read and understand the following: [a check mark was placed before each of the following]: - I have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section] 144G.45, my building(s) must comply with subdivisions 1-3 of the section, as applicable section Laws 2020, 7th Spec. [special] Sess [session]., chpt. [chapter] 1. art. [article] 6, sect. 17. - I have read and fully understand Minn. Stat. sect. 144G.80, 144G.81. and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22, my building(s) must comply with these sections if applicable. - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G.	{0 250}		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{0 250}	Continued From page 9 - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659. - Reporting of Maltreatment of Vulnerable Adults. - Electronic Monitoring in Certain Facilities. - I understand pursuant to Minn. Stat. sect. 13.04 Rights of Subjects of Data, the Commissioner will use information provided in this application, which may include an in-person or telephone conference, to determine if the applicant meets requirements for assisted living licensing. I understand I am not legally required to supply the requested information; however, failure to provide information or the submission of false or misleading information may delay the processing of my application or may be grounds for denying a license. I understand that information submitted to the commissioner in this application may, in some circumstances, be disclosed to the appropriate state, federal or local agency and law enforcement office to enhance investigative or enforcement efforts or further a public health protective process. Types of offices include Adult Protective Services, offices of the ombudsmen, health-licensing boards, Department of Human Services, county or city attorneys' offices, police, local or county public health offices. - I understand in accordance with Minn. Stat. sect. 144.051 Data Relating to Licensed and Registered Persons (opens in a new window), all data submitted on this application shall be classified as public information upon issuance of a provisional license or license. All data submitted are considered private until MDH issues a license.	{0 250}		

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{0 250}	Continued From page 10 - I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659 governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. - I have examined this application and all attachments and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct, and complete. I will notify MDH, in writing, of any changes to this information as required. - I attest to have all required policies and procedures of Minn. Stat. chapter 144G and Minn. Rules chapter 4659 in place upon licensure and to keep them current as applicable. Page five was electronically signed by licensed assisted living director/owner (LALD)-A on May 24, 2021. The licensee had an assisted living license issued on August 1, 2021, with an expiration date of July 31, 2022. The licensee failed to ensure the following policies and procedures were developed and/or implemented: (1) orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; (2) handling complaints regarding staff or	{0 250}		

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{0 250}	Continued From page 11 services provided by staff; (3) conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate; (4) infection control practices; (5) conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards; (6) medication and treatment management; (7) supervision of unlicensed personnel performing delegated tasks; and (8) quality improvement and quality management activities. As a result of this survey, the following orders were re-issued: 0250, 0480, 0490, 0660, 0680, 0780, 0790, 0800, 0810, 0930, 0940, 0970, 1460, 1530, 1790, and a new correction order was issued for 1750, indicating the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.08 to 144G.95. No further information was provided.	{0 250}		
{0 480} SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks	{0 480}		

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{0 480}	Continued From page 12 available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated September 6, 2022, for the specific Minnesota Food Code deficiencies.	{0 480}		
{0 490} SS=F	144G.41 Subd 1 (13) (ii)-(vii) Minimum requirements (ii) weekly housekeeping; (iii) weekly laundry service; (iv) upon the request of the resident, provide	{0 490}		

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{0 490}	Continued From page 13 direct or reasonable assistance with arranging for transportation to medical and social services appointments, shopping, and other recreation, and provide the name of or other identifying information about the persons responsible for providing this assistance; (v) upon the request of the resident, provide reasonable assistance with accessing community resources and social services available in the community, and provide the name of or other identifying information about persons responsible for providing this assistance; (vi) provide culturally sensitive programs; and (vii) have a daily program of social and recreational activities that are based upon individual and group interests, physical, mental, and psychosocial needs, and that creates opportunities for active participation in the community at large; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to have a daily program of social and recreational activities based on individual and group interests, physical, mental and psychosocial needs. This had the potential to affect all four residents residing at 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) 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).	{0 490}		

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{0 490}	Continued From page 14 The findings include: The facility was licensed as an assisted living facility. On September 6, 2022, between approximately 11:00 a.m., and 4:30 p.m., the surveyor observed no activities, either planned or offered to residents. The basement living room of the facility had a TV, exercise equipment and board games and there was small TV located in the upstairs living room. During the time noted above, the surveyor observed one resident go outside the facility to smoke two different times. Although not required, there was no posted activity calendar or other disclosure of any upcoming, planned activities and events for residents. On September 6, 2022, at approximately 12:42 p.m., registered nurse (RN)-D stated they have talked to the management about an activity program for residents, and it was something they were still working on. On September 7, 2022, at approximately 8:22 a.m., R2 stated, "I take care of entertaining myself" and "do my own thing" for a social life. When the surveyor asked what activities or social things were offered or planned by the facility, R2 said they had no program and asked, "Do you see anything posted or is there a schedule of events?" R2 said he has seen staff take residents out to the store, but said it was not a group thing or planned. Although unlikely to participate in a facility-planned outing, R2 said he was not the only one who lived here. On September 7, 2022, at approximately 11:05 a.m., program manager (PM)-C talked about outings going on at their other sites and said	{0 490}		

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{0 490}	Continued From page 15 residents at this location were not interested. PM-C stated they have offered activities, but residents at this location responded with no interest to participate. PM-C acknowledged, however, there were no current, planned activities and offered no evidence activities were offered or scheduled for residents. No further information was provided.	{0 490}		
{0 660} SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (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. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) and failed to ensure TB education, commensurate with job responsibilities, was	{0 660}		

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{0 660}	Continued From page 16	{0 660}		

provided and documented for one of two employees, (unlicensed personnel (ULP)-G.)

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's Facility Tuberculosis (TB) Risk Assessment dated January 3, 2022, indicated a low risk level.

ULP-G started employment on May 10, 2022.

On September 6, 2022, 11:09 a.m., the surveyor observed ULP-G administer medications to R2.

ULP-G's employee record lacked evidence of having completed TB training at time of hire, as required.

On September 7, 2022, at approximately 11:07 a.m., registered nurse (RN)-D and program manager (PM)-B verified the lack of TB training for ULP-G. PM-B said they used EduCare (a computer-based training program) and would make sure staff completed the course that included TB education.

The licensee's Infection Control, 8.16 Tuberculosis Screening policy, undated, indicated staff would be educated regarding TB at time of hire. Further, training should be appropriate to the

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{0 660}	Continued From page 17 job responsibilities and educational or professional background of the employee and content of the training included TB pathogenesis, transmission, signs and symptoms of active TB and the licensee's infection control plan. The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and based on CDC guidelines, indicated an employee may begin working with patients after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW (health care worker) starts working with patients. Baseline TB screening should be documented in the employee's record. In addition, the guidelines include, "TB training is required at time of hire for all HCWs." No further information was provided.	{0 660}		
{0 680} SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents;	{0 680}		

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{0 680}	Continued From page 18 (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a written emergency preparedness plan with all the required content and failed to post an emergency preparedness plan prominently. This had the potential to affect all four current residents, staff and any visitors to 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) 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 September 6, 2022, at approximately 11:50 a.m., the surveyor requested to view the licensee's emergency preparedness (EP) plan, including corrections made following the original	{0 680}		

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{0 680}	Continued From page 19 survey in July. Licensed assisted living director (LALD)-A produced their "Emergency Preparedness Manual" which the surveyor recalled from the original survey and later reviewed. The surveyor asked if the EP plan had been updated. LALD-A said they were going to make changes based on receipt of the final survey report from the state. LALD-A acknowledged he only opened the email from the state today, which was delivered to the licensee electronically on August 15, 2022, and said he did not know the email wound up in the "junk" email. Regarding the EP plan, LALD-A said they updated some of the signage but had not made other changes to the plan since the last survey. One of the first pages of the licensee's "Emergency Preparedness Manual," was a signature page, with place to document the date of review of the plan; it was blank. The manual contained documents, forms and information about emergency preparedness (EP) planning. There were numerous forms/checklists including: a hazard-vulnerability assessment tool (which was not completed or dated), a communication plan template, phone number list, location of fire extinguisher drawing, emergency information for resident, fire drill log and audit tool. The manual contained policies for fire safety, missing resident and a general EP policy. The bulk of the manual was instruction on how to create an EP plan. Although some pages of the manual were identified with the licensee's name and address and a number of forms were partially filled out, the manual was otherwise incomplete and as presented was not a developed, facility-tailored EP plan. The licensee lacked an emergency preparedness plan to address the following requirements:	{0 680}		

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{0 680}	Continued From page 20 -current, all-hazards approach facility assessment; -description of the population served by licensee; -process for emergency preparedness (EP) cooperation with state and local EP officials/organizations; -subsistence needs for staff and residents during emergency situation; -procedure for tracking staff and residents; -development of all policies/procedures, based on assessment; and additional policies for: -potential evacuation; -sheltering in place; -handling medical documents; -handling and use of volunteers; -arrangement with other faculties (including sister facilities); -development of a communication plan, including primary and alternate means for communication; -methods for sharing information; -EP training and testing program; -EP training program for staff (including documentation of training provided); and -annual EP testing requirements. On September 6, 2022, at approximately 2:26 p.m., registered nurse (RN)-D talked about how they planned to correct the citation about the emergency plan. RN-D said they contacted a consultant regarding the evacuation plan and were working on new signage but said she really did not know about the other components of the plan. RN-D acknowledged parts of the plan were incomplete. On September 7, 2022, at approximately 11:09 a.m., program manager (PM)-C acknowledged the EP was not complete and stated, "we'll have to review that while we have our meeting following this survey."	{0 680}		

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{0 680}	Continued From page 21 The licensee's 9.0 Emergency Preparedness Plan - Appendix Z Compliance policy, undated, indicated it is the intent the licensee has in place an effective and compliant emergency preparedness plan that is aligned with Appendix Z (the state-adopted tool for emergency plan development). The plan would include four primary components: risk assessment and planning; policies and procedures; a communication plan and staff training and exercises/drills. No further information was provided.	{0 680}		
{0 780} SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing	{0 780}		

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{0 780}	Continued From page 22 smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure smoke alarms are interconnected so that actuation of one alarm causes all alarms in the dwelling to actuate as required. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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 residents). The findings include: On September 6, 2022, between 1:00 p.m. and 2:00 p.m., survey staff toured the facility with the registered nurse (RN)-D. During the facility tour, survey staff observed that the smoke alarms were not interconnected in the facility. RN-D verbally confirmed survey staff observations during the facility tour. No further information was provided.	{0 780}		
{0 790} SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment	{0 790}		

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{0 790}	Continued From page 23 (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure the maintenance of portable fire extinguishers at the facility. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all residents). The findings include: On September 6, 2022, from approximately 1:00 p.m. to 2:00 p.m., survey staff toured the facility with the registered nurse (RN)-D. During the facility tour, survey staff observed fire extinguishers did not have inspection tags. RN-D verbally confirmed survey staff observations during the facility tour and stated they had not done any inspections for the	{0 790}		

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{0 790}	Continued From page 24 extinguishers. No further information was provided.	{0 790}		
{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 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. 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 residents). The findings include: On September 6, 2022, from approximately 1:00 p.m. to 2:00 p.m., survey staff toured the facility with the registered nurse (RN)-D. During the facility tour, survey staff observed the following:	{0 800}		

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{0 800}	Continued From page 25 4. The garage floor had a large crack in the concrete running the width of the garage. 2. The storage room beneath the garage had a matching crack in the ceiling with signs of water damage. The ceiling was sagging in the middle and had some discoloration and dark staining on the ceiling material. There was exposed batt insulation running between the pipes and the exterior foundation wall. The insulation looked to have water damage but was dry to the touch at the time of the survey. The fiberglass in the insulation was slumping away from the wall and had some discoloration and dark staining. Mattresses, cardboard boxes, and miscellaneous furniture was stored in the storage room. The room smelled strongly of a wet, musty basement and everything was covered in spider webs and cobwebs. The concrete floor was stained in the shape of ponding water or other liquid near the foundation wall. 3. The ceiling access panel in the garage was missing. 4. The egress windows in all basement bedrooms were not easy to open. The hardware appeared to be stiff and difficult to use due to infrequent use and no maintenance done. Personal belongings of the residents in the basement bedrooms partially obstructed all the egress windows, windows were still accessible. 5. Lower level bathroom had water damage on the wall behind the toilet and the adjacent sink vanity. Mushrooms were growing from behind the sink vanity. The wood end panel of the vanity and wood floor of the cabinet were wet, wrinkled, and had peeling paint on them. The wall behind the	{0 800}		

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{0 800}	Continued From page 26 toilet had evidence of water running down the surface. The paint on the wall was bubbled in some areas and damp to the touch. 6. The lower level laundry area had water damage on the wall behind the washer and dryer, Mushrooms were growing behind the washing machine. The wall adjacent to the equipment was bubbled in some areas and damp to the touch. Survey staff could not observe what was causing the damage. Both the lower level bathroom and laundry area shared an interior plumbing wall. RN-D verbally confirmed survey staff observations during the facility tour. No further information was provided.	{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	{0 810}		

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{0 810}	Continued From page 27 plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one 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 interview and record review, the licensee failed to develop and maintain fire safety and evacuation plans and failed to provide required training to residents and employees for fire safety and evacuation. This had the potential to affect all current residents, staff, and visitors to 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 the potential to affect a large portion or all residents). The findings include: During interview on September 6, 2022, at 2:15	{0 810}		

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{0 810}	Continued From page 28 p.m., the registered nurse (RN)-D stated she would send over records of staff and resident training for fire safety and evacuation. Survey staff never received an email containing the requested records. Review of the fire policy "9.06 Fire Policy, dated 'xx/xx/xxx'", from Care Providers of Minnesota, showed the following: 1. No evacuation plan or documentation on specific procedures for the residents including procedures for their movements, and relocation during a fire or similar emergency. No written instructions for addressing any unique situation during an evacuation, especially for residents who are wheelchair-bound and need assistance during an evacuation. The policy was a basic policy from a third-party provider and had not been edited or updated to fit the facility. 2. No schedule or records on the training of employees on fire safety and evacuation; on proper actions to take in the event of a fire or emergency for the safety of residents including movement, evacuation, or relocation. 3. No schedule or records on the training of residents who are capable of assisting in their evacuation; on proper actions to take in the event of a fire or emergency for their safety including movement, evacuation, or relocation. No further information was provided.	{0 810}		
{0 930} SS=C	144G.50 Subd. 2 (d-e; 1-4) Contract information (d) The contract must include a description of the facility's complaint resolution process available to	{0 930}		

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{0 930}	Continued From page 29	{0 930}		

residents, including the name and contact information of the person representing the facility who is designated to handle and resolve complaints.
(e) The contract must include a clear and conspicuous notice of:
(1) the right under section 144G.54 to appeal the termination of an assisted living contract;
(2) the facility's policy regarding transfer of residents within the facility, under what circumstances a transfer may occur, and the circumstances under which resident consent is required for a transfer;
(3) contact information for the Office of Ombudsman for Long-Term Care, the Ombudsman for Mental Health and Developmental Disabilities, and the Office of Health Facility Complaints;
(4) the resident's right to obtain services from an unaffiliated service provider;

This MN Requirement is not met as evidenced by:
Based on observation, interview and record review, the licensee failed to execute a written assisted living contract with the required content for two of two residents (R1, R2).

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).

The findings include:

R1 and R2's contracts lacked the following

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{0 930}	Continued From page 30	{0 930}		

content:
-description of the assisted living facility's complaint resolution process, including the name and contact information of the person representing the facility who is designated to hand and resolve complaints.

R1
On September 6, 2022, at approximately 11:09 a.m., the surveyor observed ULP-G administer medications to R1.

R1's Resident Contract for Assisted Living, signed by R1 on July 2, 2022, lacked content listed above.

R2
R2's Resident Contract for Assisted Living, signed by R2 on June 20, 2022, lacked content listed above.

On September 6, 2022, registered nurse (RN)-D and RN-H stated they had planned to update each resident's file following the original survey in July. RN-H stated they had a new contract template, but had not given the contract to residents. Licensed assisted living director (LALD)-A mentioned he had only opened the email containing the final report for the survey in July earlier today (delivered to the licensee electronically on August 15, 2022) and said they would have made changes based on what was in the survey report. LALD-A said all residents would have the same contract, which LALD-A acknowledged was not updated since the July survey.

The licensee's 1.05 Signing an Assisted Living Contract policy, undated, indicated when a prospective resident decides to move into the

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{0 930}	Continued From page 31 facility, it requires an assisted living contract signed and received by the facility. The policy did not address the content of the contract. No further information was provided.	{0 930}		
{0 940} SS=C	144G.50 Subd. 2 (e; 5-7) Contract information (5) a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including: (i) whether the facility is enrolled with the commissioner of human services to provide customized living services under medical assistance waivers; (ii) whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b); (iii) whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided; (iv) whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required; (v) a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent; (vi) a statement that residents may be eligible for assistance with rent through the housing support program; and (vii) a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program;	{0 940}		

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{0 940}	Continued From page 32 (6) the contact information to obtain long-term care consulting services under section 256B.0911; and (7) the toll-free phone number for the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to execute a written assisted living contract with the required content for two of two residents (R1, R2) with records reviewed. 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). The findings include: R1's and R2's assisted living contracts lacked the following content: -a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including: -whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided; -whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of	{0 940}		

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{0 940}	Continued From page 33	{0 940}		

time that private payment is required;
-a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent;
-a statement that residents may be eligible for assistance with rent through the housing support program;
-a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program; and
-the contact information to obtain long-term care consulting services under section 256B.0911.

R1
On September 6, 2022, at approximately 11:09 a.m., the surveyor observed ULP-G administer medications to R1.

R1's Resident Contract for Assisted Living, signed by R1 on July 2, 2022, lacked content listed above.

R2
R2's Resident Contract for Assisted Living, signed by R2 on June 20, 2022, lacked content listed above.

On September 6, 2022, registered nurse (RN)-D and RN-H stated they had planned to update each resident's file following the original survey in July. RN-H stated they had a new contract template, but had not given the contract to residents. Licensed assisted living director (LALD)-A mentioned he had only opened the email containing the final report for the survey in July earlier today (deliever to the licensee electronically on August 15, 2022) and said they would have made changes to the contracts based on what was in the survey report. LALD-A said all

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{0 940}	Continued From page 34 residents would have the same contract, which LALD-A acknowledged was not updated since the July survey. The licensee's 1.05 Signing an Assisted Living Contract policy, undated, indicated when a prospective resident decides to move into the facility, it requires an assisted living contract signed and received by the facility. The policy did not address the content of the contract. No further information was provided.	{0 940}		
{0 970} SS=F	144.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the facility's liability for health, safety, or personal property of a resident. This had the potential to affect all residents. This practice resulted in a level 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	{0 970}		

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or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).

The findings include:

The assisted living contract included two clauses that indicated the resident would waive the facility's liability for health, safety, or personal property of a resident. Page 15, section 27 titled "Indemnification," the contract indicated: Resident will indemnify and hold harmless landlord, its employees and agents from and against any and all claims, actions, damages and liability and expense in connection with loss of life, personal injury or damage to property, arising from or out of the use by resident of the rented premises or any other part of the landlord's property, or caused wholly or in part by an act or omission of resident or resident's guests or agents.

On page 16 of the contract, in the section titled "Liability," the contract indicated: Landlord is not liable to resident or resident's guests for any injury, death or property damage occurring in room or on provider's premises unless such injury, death or property damage occurs as a result of an equipment malfunction or hazardous condition within the building not caused by resident or resident's guests. Landlord is also not liable for any injury, death or damage occurring as the result of resident's receipt of health-related, supporting or other services from third part providers. Landlord may be liable to resident for its own negligent acts of those of its employee or agents. Unless caused by one of the aforementioned excepted reasons, resident agrees to hold landlord harmless from any and all claims for injuries, property damage or any other loss resulting from and accident or other

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{0 970}	Continued From page 36 occurrence in the room or on landlord's premises. On September 6, 2022, registered nurse (RN)-D and RN-H stated they had planned to update each resident's file following the original survey in July. RN-H stated they had a new contract template, but had not given the contract to residents. Licensed assisted living director (LALD)-A mentioned he had only opened the email containing the final report for the survey in July earlier today (delivered to the licensee electronically on August 15, 2022) and said they would have made changes based on what was in the survey report. LALD-A said all residents would have the same contract, which LALD-A acknowledged was not updated since the July survey. The licensee's 1.05 Signing an Assisted Living Contract policy, undated, indicated when a prospective resident decides to move into the facility, it requires an assisted living contract signed and received by the facility. The policy did not address the content of the contract. No further information was provided.	{0 970}		
{01460} SS=F	144G.63 Subdivision 1 Orientation of staff and supervisors 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.	{01460}		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{01460}	Continued From page 37 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to provide staff orientation to assisted living licensing requirements and regulations for two of two employees (registered nurse (RN)-D and unlicensed personnel (ULP)-G). This has the potential to affect all four residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: RN-D RN-D was hired on February 17, 2020, under the comprehensive home care license and began providing assisted living services on August 1, 2021. Review of resident and personnel records indicated RN-D conducted nursing assessments for the licensee's residents and provided training to the licensee's staff. ULP-G ULP-G was hired May 10, 2022, to provide direct care services to the licensee's residents. On September 6, 2022, at approximately 11:09 a.m., the surveyor observed ULP-G administer medications to R1.	{01460}		

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	37197	A. BUILDING: _____ B. WING _____	R 09/07/2022

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{01460}	Continued From page 38 RN-D and ULP-G's employee records lacked evidence lacked evidence their orientation to assisting living facility requirements was completed timely and included: -overview of assisted living statutes; -review of providers' policies and procedures; -handling of emergencies and using emergency services; -reporting maltreatment of vulnerable adults or minors; -assisted living bill of rights; -handling of resident's complaints, reporting of complaints and where to report; -consumer advocacy services; -review of the types of assisted living services the employee will provide and providers' scope of license; -principles of person-centered planning/service delivery; and -hearing loss training (optional). On September 7, 2022, at approximately 11:12 a.m., program manager (PM)-C acknowledged the missing orientation to assisted living for RN-D and ULP-G. PM-C and registered nurse (RN)-D said they were aware orientation was required for all staff, was not transferable between facilities and was to be completed before staff worked with residents. PM-C stated orientation was missing for all staff and she was responsible to see that all staff have orientation. PM-C said, "We need to go back and re-train all staff on this. This would be the plan." The licensee's 5.01 Orientation of Staff and Supervisors & Content policy, undated, directed all staff providing and supervising direct services must complete an orientation to Assisted Living facility licensing requirements. The policy	{01460}		

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{01460}	Continued From page 39 indicated the orientation must contain the topics identified above and evidence of completion of required orientation must be kept in each employee's record. No further information was provided.	{01460}		
{01530} SS=F	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (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; (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 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; This MN Requirement is not met as evidenced by:	{01530}		

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{01530}	Continued From page 40 Based on observation, interview and record review, the licensee failed to ensure staff received required dementia care training in the required time frame for two of two employees, registered nurse (RN)-D and unlicensed personnel (ULP)-G. This had the potential to affect all four current residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 finding include: RN-D RN-D was hired February 17, 2020, to provide and supervise direct care services to the licensee's residents. Review of resident and personnel records indicated RN-D conducted nursing assessments and created service plans for the licensee's residents and also provided training to the licensee's staff. RN-D's record indicated the employee did not complete eight required (8) hours of training in dementia care within 120 hours of the employee's start date. The record indicated RN-D completed only 3.25 hours of training as of September 6, 2022. ULP-G ULP-G was hired May 10, 2022, to provide direct care services to the licensee's residents.	{01530}		

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{01530}	Continued From page 41 On September 6, 2022, at approximately 11:09 a.m., the surveyor observed ULP-G administer medications to R1. ULP-G's record indicated the employee did not complete eight (8) required hours of training in dementia care within 160 hours of the employee's start date. The record indicated ULP-G completed only 5.0 hours of dementia training as of September 6, 2022. On September 7, 2022, at approximately 11:16 a.m., program manager (PM)-C said they had issues with the computer-based training system and staff were not able to complete dementia training. However, PM-C acknowledged they were deficient in making sure all staff had completed required training in dementia care. The licensee's 5.03 Dementia Training policy, undated, indicated all staff are required to complete dementia training at the time of hire and annually thereafter. The policy indicated supervisors of direct care stall will complete eight hours of initial training within 120 of employment start date; and direct care staff will complete eight hours within 160 hours of employment start date. No further information was provided.	{01530}		
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,	01750		

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01750	Continued From page 42	01750		

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 licensee failed to ensure one of one unlicensed personnel (ULP)-G, followed appropriate medication administration procedures during a medication pass.

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 September 6, 2022, at approximately 11:10 a.m., R1 indicated she wanted morning meds (medications) and something for pain. The surveyor observed ULP-G unlock the medication storage cupboard and retrieve a bottle of acetaminophen (pain medication) 325 mg tablets and a pharmacy-prepared bubble pack, each labeled for R1. The bubble pack had rows and columns of cells, which were clear, plastic containers for pills. Each row had four cells and each cell contained pills for different times of day (morning, noon, afternoon and evening). The cell

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01750	Continued From page 43	01750		

on R1's bubble pack for Tuesday, September 6, "morning", contained a capsule and small round pill. The cell was labeled with the medication's name, strength and dispensing instructions. The label indicated R1 received Gabapentin (for mood stabilization) 300 mg (milligram) capsule and topiramate (for mood) 25 mg tablet.

Without referencing R1's medication administration record (MAR), the surveyor observed ULP-G open the acetaminophen bottle, pour two pills into a small medication cup, then punch out and empty the pills from the pharmacy-prepared bubble pack into the cup. ULP-G then gave the cup to R1 who swallowed the four pills with a glass of water. After disposing the cup, ULP-G retrieved the MAR from the cupboard and documented R1's medication administration.

On September 6, 2022, at approximately 11:28 a.m., the surveyor and ULP-G discussed the observation made regarding R1's medication administration. ULP-G said she was trained and observed by RN-D to pass medications. When asked why she did not look at the MAR when passing out R1's medications, ULP-G said she "knew the pills" R1 took because she passed them out daily to R1. ULP-G admitted she was not trained that way and said she should be looking at the MAR to compare the labels on the pill package.

A facility document "Safety checks for Medication Administration" undated and located in R1's MAR, indicated staff were to complete "The three label checks for 6 rights - this refers to the comparison that is made between the drug label and MAR." This check was to be done three times: first when drugs are obtained from the

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01750	Continued From page 44 patient's [resident's] drawer, second when they have all the medications and re-check the MAR; and a third time when they remove the tablets from the packages. On September 6, 2022, at approximately 12:50 p.m., registered nurse (RN)-D stated staff were trained to administer medications following the 6 rights. RN-D said she could not be sure how staff passed medications when she was not there, but that the staff needed to check the medications, even if prepared by the pharmacy, and should have compared them to the MAR. RN-D said the way ULP-G administered R1's medications was "not acceptable and needed additional training and supervision." The licensee's 7.15 Medication &Treatment - Administration & Delegation policy, undated, indicated ordered or prescribed medications may be administered by a nurse or unlicensed personnel who have been delegated medication administration tasks by a RN at the facility. When administration is delegated to ULP the facility ensures the RN has instructed the ULP in the proper methods to administer the medications. The policy further indicated a RN would instruct the ULP on medication administration tasks, among which included the complete procedure of checking a resident's MAR. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		
{01790} SS=F	144G.71 Subd. 10 Medication management for residents who will	{01790}		

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{01790}	Continued From page 45 (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the	{01790}		

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{01790}	Continued From page 46	{01790}		

medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information;
(v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative;
(vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and
(vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to ensure the registered nurse (RN) developed written procedures for the unlicensed personnel (ULP) providing medications to residents having unplanned time away when the licensed nurse was not available. This had the potential to affect all four residents.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is 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:

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{01790}	Continued From page 47 The licensee's 7.10 Medication Management - Planned & Unplanned Time Away policy, undated, indicated for unplanned resident time away when a pharmacist or licensed nurse was not available, the RN could delegate this task to ULP if the RN had developed written procedures for the ULP including any special instructions or procedures regarding controlled substances that were prescribed for the resident. The written procedure must address: - the type of container or containers to be used for the medications appropriate to the provider's medication system; - how the container or containers must be labeled; - written information about the medications to be provided; - how the ULP must document in the resident's record that medications have been provided, including documenting the date the medications where provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; - how the RN would be notified that medications have been provided and whether the RN needs to be contacted before the medications are given to the resident or the designated representative; - a review by the RN of the completion of this task to verify that this task was completed accurately by the ULP; and - how the ULP must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each medication returned. On September 7, 2022, at approximately 11:16	{01790}		

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{01790}	Continued From page 48 a.m., RN-D verified that while not all of their current residents took medications, they provided medication management services, which included storage of medications and limiting the resident's access to their medications. Regarding unplanned time away, RN-D said they had the policy, but did not have a written, documented procedure for the unlicensed staff to follow so they could pass out medications to residents who went away from the house for a time. RN-D said, "We will work on that." No further information was provided.	{01790}		

Electronically Delivered

August 15, 2022

Administrator
Unique Homes, LLC
3940 46th Avenue North
Robbinsdale, MN 55422

RE: Project Number(s) SL37197015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on July 14, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health 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 enclosed State Form documents the state licensing orders. The Department of Health 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 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.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation

that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The Department of Health 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 (a)(5)(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, no immediate fines are assessed.

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up evaluations. The licensee is not required to submit a plan of correction 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 issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by the Department of Health within 15 calendar days of the correction order receipt date.

A state licensing 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 general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

Please address your cover letter for general reconsideration requests to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place

Free from Maltreatment reconsideration requests should be addressed to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place

St. Paul, MN 55164-0970 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 this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,

Casey DeVries, Supervisor
State Evaluation Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-201-5917 Fax: 651-215-9697

PMB

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0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL37197015-0 On July 12, 2022, through July 14, 2022, 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 four residents, all of whom received services under the provider's Assisted Living 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.	
0 110 SS=F	144G.10 Subdivision 1a Assisted living director license required	0 110		

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	37197	A. BUILDING: _____ B. WING _____	07/14/2022

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0 110	Continued From page 1 Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure the licensed assisted living director (LALD) was listed as the Director of Record with the Board of Executives for Long Term Services and Supports (BELTSS). This had the potential to affect all the licensee's residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on July 12, 2022, at approximately 10:25 a.m., licensed assisted living director (LALD)-A indicated he was the LALD for the facility. On July 12, 2022, at approximately 1:54 p.m., the surveyor observed LALD-A log into the BELTSS website, which indicated LALD-A held a current assisted living director license, effective July 20, 2021. The BELTSS website did not identify LALD-A as the Director of Record for the licensee.	0 110		

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0 110	Continued From page 2 On July 12, 2022, at approximately 1:54 p.m., LALD-A acknowledged he was not listed as the Director of Record for the licensee. LALD-A stated he was not aware of the requirement but would fix the issue. The licensee's 4.01 Assisted Living Director policy, undated, indicated the facility expects the licensed director to comply with all requirements set for by BELTSS (Board of Executives for Long Term Services and Supports) as a licensed professional. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 110		
0 120 SS=C	144G.11 APPLICABILITY OF OTHER LAWS Assisted living facilities: (1) are subject to and must comply with chapter 504B; (2) must comply with section?325F.72; and (3) are not required to obtain a lodging license under chapter 157 and related rules. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure an assisted living facility, advertising dementia care, had an assisted living dementia care license in place. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a	0 120		

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0 120	Continued From page 3 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: The facility was licensed as an assisted living facility. During the entrance conference on July 12, 2022, at approximately 11:10 a.m., the surveyor, with licensed assisted living director (LALD)-A, visited the facility's website. The website's home page contained a link for "Dementia Care". The "Dementia Care" link contained statements about services and care the licensee provided, including: "Intensive care and security for people who lost their cognitive ability" and "People with dementia tend to lose their cognitive ability, such as memory, thinking ability, and social skills. Thus, they need stringent care from our care professionals to prevent them from wandering, getting lost, and getting hurt. Moreover, they might feel agitated once they are overwhelmed. This is why we make sure to train our team of caregivers to properly care for dementia patients." On July 12, 2022, at approximately 11:10 a.m., licensed assisted living director (LALD)-A verified the facility's website contained advertisement to provide services for dementia. LALD-A said their focus was on residents with mental health issues and they did not have or admit residents with dementia. LALD-A stated he would reach out to the people who run the website and said "I'll make sure to remove that" regarding dementia care. No further information was provided.	0 120		

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0 120	Continued From page 4 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 120		
0 250 SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection,	0 250		

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0 250	Continued From page 5 survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to show they met the requirements of licensure, by attesting the managerial officials who oversaw the day-to-day operations understood applicable statutes and rules; nor developed and/or implemented current policies and procedures as required with records reviewed. This had the potential to affect all residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is 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).	0 250		

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0 250	Continued From page 6 The findings include: During the entrance conference on July 12, 2022, at approximately 10:37 a.m., licensed assisted living director (LALD)-A stated the licensee's employees in charge of the facility were familiar with the assisted living regulations and the licensee provided medication and treatment management services. The licensee's Application for Assisted Living License, section titled Official Verification of Owner or Authorized Agent, (page four and five of the application), identified, I certify I have read and understand the following: [a check mark was placed before each of the following]: - I have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section] 144G.45, my building(s) must comply with subdivisions 1-3 of the section, as applicable section Laws 2020, 7th Spec. [special] Sess [session]., chpt. [chapter] 1. art. [article] 6, sect. 17. - I have read and fully understand Minn. Stat. sect. 144G.80, 144G.81. and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22, my building(s) must comply with these sections if applicable. - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G. - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659. - Reporting of Maltreatment of Vulnerable Adults.	0 250		

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0 250	Continued From page 7 - Electronic Monitoring in Certain Facilities. - I understand pursuant to Minn. Stat. sect. 13.04 Rights of Subjects of Data, the Commissioner will use information provided in this application, which may include an in-person or telephone conference, to determine if the applicant meets requirements for assisted living licensing. I understand I am not legally required to supply the requested information; however, failure to provide information or the submission of false or misleading information may delay the processing of my application or may be grounds for denying a license. I understand that information submitted to the commissioner in this application may, in some circumstances, be disclosed to the appropriate state, federal or local agency and law enforcement office to enhance investigative or enforcement efforts or further a public health protective process. Types of offices include Adult Protective Services, offices of the ombudsmen, health-licensing boards, Department of Human Services, county or city attorneys' offices, police, local or county public health offices. - I understand in accordance with Minn. Stat. sect. 144.051 Data Relating to Licensed and Registered Persons (opens in a new window), all data submitted on this application shall be classified as public information upon issuance of a provisional license or license. All data submitted are considered private until MDH issues a license. - I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659 governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and	0 250		

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0 250	Continued From page 8 operation of the facility, regardless of the existence of a management agreement or subcontract. - I have examined this application and all attachments and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct, and complete. I will notify MDH, in writing, of any changes to this information as required. - I attest to have all required policies and procedures of Minn. Stat. chapter 144G and Minn. Rules chapter 4659 in place upon licensure and to keep them current as applicable. Page five was electronically signed by licensed assisted living director/owner (LALD)-A on May 24, 2021. The licensee had an assisted living license issued on August 1, 2021, with an expiration date of July 31, 2022. The licensee failed to ensure the following policies and procedures were developed and/or implemented: (1) orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; (2) handling complaints regarding staff or services provided by staff; (3) conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified,	0 250		

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0 250	Continued From page 9 managed, and communicated to staff and other health care providers as appropriate; (4) infection control practices; (5) conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards; (6) medication and treatment management; (7) supervision of unlicensed personnel performing delegated tasks; and (8) quality improvement and quality management activities. On July 14, 2022, at approximately 11:25 a.m., during the exit conference, registered nurse (RN)-D confirmed the licensee provided orientation, skill training and supervision to staff, conducted resident assessments, medication management services and other direct-care services to residents but failed to implement corresponding policies and procedures, as required. As a result of this survey, the following orders were issued: 0110, 0120, 0250, 0470, 0480, 0485, 0490, 0550, 0570, 0580, 0660, 0680, 0780, 0790, 0800, 0810, 0930, 0940, 0970, 1370, 1380, 1440, 1460, 1470, 1530, 1610, 1640, 1650, 1730, 1770, 1790, 1820, 1910 and 3090 indicating the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.08 to 144G.95. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 250		

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0 470	Continued From page 10	0 470		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop and implement a staffing plan to determine staffing levels to meet the needs of all residents. This had the potential to affect all four residents and staff.	0 470		

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0 470	Continued From page 11 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 licensee held an assisted living facility license. During the entrance conference on July 12, 2022, at approximately 10:44 a.m., the surveyor requested a copy of the facility's staffing plan from registered nurse (RN)-B. During a facility tour on July 12, 2022, at approximately 11:44 a.m., with program manager (PM)-C, the surveyor observed the main common area, where the daily staffing schedule was posted. The document did not indicate how the staffing levels were determined. On July 14, 2022, at approximately 11:49 a.m., registered nurse (RN)-B verified the licensee had no documented staffing plan. The licensee's Staffing and Schedule Policy, undated, indicated the clinical nurse supervisor will develop and implement a written staffing plan that provided an adequate number of qualified direct-care staff to meet the residents' needs 24-hours a day, seven-days a week. The daily work schedule would be posted at the beginning of each work shift in a central location in each building of a facility or campus, showing all work shifts and hours worked and work assignments. No further information was provided.	0 470		

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0 470	Continued From page 12 TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (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 comply with Minnesota Food Code, Chapter 4626. This had the potential to affect all four residents at 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected	0 480		

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0 480	Continued From page 13 or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated July 12, 2022, for the specific Minnesota Food Code deficiencies. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 485 SS=C	144G.41 Subd 1. (13) (i) (A) and (C) Minimum Requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (A) menus must be prepared at least one week in advance, and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes; (C) the facility cannot require a resident to include and pay for meals in their contract;	0 485		

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0 485	Continued From page 14 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to have menus prepared at least one week in advance and made available to all residents. This had the potential to affect all four residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During a facility tour on July 12, 2022, at about 12:30 p.m., the surveyor observed no food menu posted. On July 12, 2022, at approximately 2:28 p.m., program manager (PM)-C stated they did not have a menu. PM-C stated in the past there was a posted menu, but residents were unhappy about what was offered, so the licensee had a meeting about what to do. PM-C said since then they did not have a fixed menu. On July 12, 2022, at approximately 1:57 p.m., R1 stated she only recently moved in and but was pretty sure no menu was posted. R1 said the staff asked her what she liked and wanted to eat and they have done that. On July 13, 2022, at approximately 7:25 a.m., R3 talked with the surveyor about food and said there was no posted menu but added "that was no big	0 485		

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0 485	Continued From page 15 deal." During the exit conference on July 14, 2022, at approximately 12:14 pm., registered nurse (RN)-B acknowledged they did not post the food menu in advance and expressed understanding it was required for licensure compliance. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 485		
0 490 SS=F	144G.41 Subd 1 (13) (ii)-(vii) Minimum requirements (ii) weekly housekeeping; (iii) weekly laundry service; (iv) upon the request of the resident, provide direct or reasonable assistance with arranging for transportation to medical and social services appointments, shopping, and other recreation, and provide the name of or other identifying information about the persons responsible for providing this assistance; (v) upon the request of the resident, provide reasonable assistance with accessing community resources and social services available in the community, and provide the name of or other identifying information about persons responsible for providing this assistance; (vi) provide culturally sensitive programs; and (vii) have a daily program of social and recreational activities that are based upon individual and group interests, physical, mental, and psychosocial needs, and that creates opportunities for active participation in the community at large; and	0 490		

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0 490	Continued From page 16 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to have a daily program of social and recreational activities based on individual and group interests, physical, mental and psychosocial needs. This had the potential to affect all four residents residing at 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The facility was licensed as an assisted living facility. During observations on July 12 and July 13, 2022, between approximately 7:00 a.m., and 5:00 p.m. the surveyor observed no activities, either planned or offered to residents. The surveyor noted one resident left the facility each day, but the remaining residents spent time in their rooms most of the day, only coming out for a meal or to go outside to smoke. The basement living room of the facility had a TV, exercise equipment and board games. On July 12, 2022, at approximately 2:19 p.m., R1 stated she was not aware of any activities, but said she would possibly participate or go somewhere if that was offered. R1 said she had	0 490		

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0 490	Continued From page 17 not seen any activity schedule in the couple of weeks she had been there. On July 13, 2022, at approximately 7:50 a.m., R3 said as far as he knew, nothing was scheduled for group activities. R3 said there were some games in the basement but there was nothing planned and no posted activity schedule. On July 14, 2022, at approximately 11:50 a.m., RN-B confirmed the licensee had not developed a daily activity program for this site. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 490		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities, and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to post required information related to its grievance procedure,	0 550		

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0 550	Continued From page 18	0 550		

contact information for the Office of Ombudsman and information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center (MAARC). This had the potential to affect all residents, staff and visitors.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), 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 July 12, 2022, at approximately 11:22 a.m., the surveyor toured the facility with program manager (PM)-C. The surveyor observed the main floor common areas (dining/kitchen and adjacent living room) and downstairs areas (living/recreation room and resident room with hallway); all areas lacked required postings.

The licensee lacked a posting of the grievance procedure to include the name and e-mail contact information for the individuals(s)who are responsible for handling resident grievances. In addition, there was nothing displayed of contact information for the state and applicable regional Office of Ombudsman for Long-Term Care, the Office of Ombudsman for Mental Health and Developmental Disabilities or contact information for reporting abuse or suspected abuse the MAARC.

On July 13, 2022, at approximately 11:41 a.m., PM-C verified there was no information to report abuse, or information to contact the Ombudsman.

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0 550	Continued From page 19 PM-C also verified only the complaint form was posted which also lacked required content. The licensee's Complaint/Grievance Posting policy, undated, indicated the licensee would post, in a conspicuous place, information about our complaint/grievance procedure and the name, telephone number and email contact information for the individuals responsible for handling resident complaints/grievances. Also, the policy indicated the licensee would post contact information for the Office of Ombudsman for Mental Health and Developmental Disabilities, the Ombudsman for long-term care and the Minnesota Adult Abuse Reporting Center. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 550		
0 570 SS=C	144G.42 Subdivision 1 Display of license The original current license must be displayed at the main entrance of each assisted living facility. The facility must provide a copy of the license to any person who requests it. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to display its current assisted living license in the main entrance of the facility. This had the potential to affect all four residents, staff and visitors to the facility. 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	0 570		

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0 570	Continued From page 20 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). The findings include: Upon entrance into the facility on July 12, 2022, at approximately 10:22 a.m., the surveyor observed the main entry the living/dining area and kitchen and the facility license was not posted. Later at approximately 11:22 a.m., the surveyor toured the facility with program manager (PM)-C which included observations of entryways, hallways, downstairs and common areas. The facility's assisted living licensee was not posted, and this was confirmed by PM-C. On July 14, 2022, at approximately 11:53 a.m., PM-C acknowledged the rule regarding the posting of their license and mentioned it was now posted. The licensee's Assisted Living License and Posting policy, undated, indicated the licensee would maintain a current assisted living license issued by the Minnesota Department of Health and that the issued license will be posted at the main entrance of the facility. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 570		
0 580 SS=F	144G.42 Subd. 2 Quality management	0 580		

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0 580	Continued From page 21 The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to engage in and maintain documentation of quality management activity commensurate with the size of the business. This had the potential to affect all four residents receiving assisted living services. 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 is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on July 12, 2022, at approximately 11:59 a.m., the surveyor requested to view documentation or evidence of the licensee's current quality improvement plan	0 580		

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0 580	Continued From page 22 and meetings. Licensed assisted living director (LALD)-A provided the surveyor with staff training material regarding medication administration and documentation and staff participation lists. The provided documents did not provide evidence of a quality management program. At the exit conference on July 14, 2022, at approximately 11:55 a.m., program manager (PM)-C stated they had quality management when they first started the business but acknowledged there was no documentation of any current program. Registered nurse (RN)-B and PM-C stated this was something they would "not take lightly" and would implement a quality program at this facility. The licensee's Quality Improvement Project policy, undated, indicated the licensee would have at least one documented quality management project in place at all times, and retain records of such projects for at least two years. The licensee shall engage in quality management appropriate to the size of the provider and relevant to the type of services it provides and could include review of state survey results. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 580		
0 660 SS=E	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control	0 660		

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0 660	Continued From page 23 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. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) and failed to ensure TB history and symptoms screening was completed and documented for one of two employees (unlicensed personnel (ULP)-E). In addition, the licensee failed to ensure TB education, commensurate with job responsibilities, was provided and documented for two of two employees (ULP-E and registered nurse (RN)-D) with employee records reviewed. 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	0 660		

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0 660	Continued From page 24 situation has occurred repeatedly; but is not found to be pervasive). The findings include: The licensee's Facility Tuberculosis (TB) Risk Assessment dated January 3, 2022, indicated a low risk level. ULP-E ULP-E started employment on April 7, 2022. On July 13, 2022, at approximately 8:44 a.m., the surveyor observed ULP-E administer morning medications to R2 and later to R1. ULP-E's employee record lacked evidence of a TB health history and symptom screen and of having completed TB training at time of hire, as required. RN-D RN-D started employment on February 17, 2020. Review of resident and personnel records indicated RN-D conducted nursing assessments for the licensee's residents and provided training to the licensee's staff. RN-D's employee record lacked evidence of having completed TB training at time of hire, as required. During the exit conference on July 14, 2022, at approximately 11:56 a.m., RN-B acknowledged ULP-E's missing TB screening and the lack of documented TB training for the employees. RN-B said they would work to address these issues. The licensee's Tuberculosis Exposure Control	0 660		

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0 660	Continued From page 25 Plan, undated, indicated new staff would be screened for active signs of TB using the Baseline TB Screening Tool for HCW's (health care workers) and would have a blood test or a two-step tuberculin skin test. In addition, staff TB screening results would be kept in each employee medical file. Further, the policy indicated staff would be educated regarding TB at the time of hire. The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and based on CDC guidelines, indicated an employee may begin working with patients after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW (health care worker) starts working with patients. Baseline TB screening should be documented in the employee's record. In addition, the guidelines include, "TB training is required at time of hire for all HCWs." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses	0 680		

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0 680	Continued From page 26 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 tenant 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 observation, interview and record review, the licensee failed to have a written emergency preparedness plan with all the required content and failed to post an emergency preparedness plan prominently. This had the potential to affect all four current residents, staff and any visitors to 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) 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).	0 680		

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0 680	Continued From page 27 The findings include: During the entrance conference on July 12, 2022, at approximately 12:20 p.m., the surveyor requested to view the licensee's emergency preparedness (EP) plan, which was later provided to and reviewed by the surveyor. On July 12, 2022, at approximately 11:22 a.m., the surveyor conducted a facility tour with program manager (PM)-C. The facility was a single-story house; the main floor was resident living room, kitchen and dining area, two resident bedrooms and egress to the garage and further outside smoking area. The lower level had three resident bedrooms, bath/shower and resident living/recreation area. Emergency exit diagrams were posted on each floor, but there was no observed signage or information displayed regarding the licensee's emergency plan anywhere in the facility. The licensee's "Emergency Preparedness Manual," undated, was a binder containing documents, forms and information about emergency preparedness (EP) planning. There were numerous forms/checklists including: a hazard-vulnerability assessment tool, communication plan template, phone number list, location of fire extinguisher drawing, emergency information for resident, fire drill log and audit tool. The manual contained policies for fire safety, missing resident and a general EP policy. The bulk of the manual was instruction on how to create an EP plan. Although some pages of the manual were identified with the licensee's name and address and a number of forms partially filled out, the manual was otherwise incomplete and as presented was not a developed, facility-tailored	0 680		

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0 680	Continued From page 28 EP plan. The licensee lacked an emergency preparedness plan to address the following requirements: -current, all-hazards approach facility assessment; -description of the population served by licensee; -process for emergency preparedness (EP) cooperation with state and local EP officials/organizations; -subsistence needs for staff and residents during emergency situation; -procedure for tracking staff and residents; -development of all policies/procedures, based on assessment; and additional policies for: -potential evacuation; -sheltering in place; -handling medical documents; -handling and use of volunteers; -arrangement with other faculties (including sister facilities); -development of a communication plan, including primary and alternate means for communication; -methods for sharing information; -EP training and testing program; -EP training program for staff (including documentation of training provided); and -annual EP testing requirements. During the exit conference on July 14, 2022, at approximately 11:58 a.m., program manager (PM)-C said she was not aware of what all was needed for the emergency plan regarding the required assessments, policies, the testing of the plan, the drills (except for fire drills) and the review of the plan. PM-C stated they would need to develop the [emergency] manual for all to use. The licensee's 9.0 Emergency Preparedness Plan - Appendix Z Compliance policy, undated,	0 680		

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	37197	A. BUILDING: _____ B. WING _____	07/14/2022

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0 680	Continued From page 29 indicated it is the intent the licensee has in place an effective and compliant emergency preparedness plan that is aligned with Appendix Z. The plan would include four primary components: risk assessment and planning; Policies and procedures; a communication plan and staff training and exercises/drills. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in	0 780		

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0 780	Continued From page 30 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 the interconnection of required smoke alarms. This has the potential to directly affect residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On July 13, 2022, approximately from 11:00 a.m. to 12:15 p.m., survey staff toured the home with the program director (PD)-F. The licensed assisted living director (LALD)-A joined for parts of the tour. During the tour, survey staff observed the home was installed with two different brands of smoke alarms. The smoke alarms located in resident sleeping rooms #1, #2, #3, and upper-level hallways sounded local when tested and were not interconnected with the home's smoke alarm system. Resident rooms #4, #5, and the lower-level hallway were provided with a wireless combination of smoke and carbon monoxide alarms, and those were interconnected. Survey staff explained that the two brands may not be compatible for the interconnection of smoke alarms and they needed to replace or reach out to the manufacturer for guidance for proper installation so when one alarm is activated, all smoke alarms	0 780		

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0 780	Continued From page 31 will sound throughout the home. The PD-F and the LALD-A verified the findings. On July 13, 2022, at approximately 1:00 p.m. at the exit interview, the PD-F and the LALD-A acknowledged the above findings. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 780		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to maintain portable fire extinguishers in accordance with the State Fire Code as required by MN Statute 144G.45 Subd(a)(2). This had the potential to directly affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 790		

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0 790	Continued From page 32 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 July 13, 2022, approximately from 11:00 a.m. to 12:15 p.m., survey staff toured the home with the program director (PD)-F. The licensed assisted living director(LALD)-A joined for parts of the tour. Survey staff observed the following findings during the tour: MINIMUM SIZE REQUIRED The portable fire extinguishers did not meet the required minimum rated type, 2-A:10-B:C. Survey staff observed the label on the unit in the kitchen with the rated type of 1-A:10-B:C. MAINTENANCE/INSPECTIONS The portable fire extinguishers were observed with no tags attached or recorded to indicate the required annual service and monthly visual inspections date from this year, or last year. Survey staff explained to the PD-F that the portable fire extinguishers must be serviced by a vendor annually and the required monthly visual inspection of each extinguisher must be performed by staff to ensure all portable extinguishers are readily available, fully charged, and operable, at their designated location, and no obvious physical damage or condition to the extinguisher to prevent their operation when needed. If extinguishers were comprised or questionable, they will need to get them to a vendor for servicing such as recharging or maintenance.	0 790		

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0 790	Continued From page 33 On July 13, 2022, at approximately 1:00 p.m. at the exit interview, the PD-F and the LALD-A acknowledged the above findings. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 790		
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, but was not likely to cause serious injury, impairment, or death), and is 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).	0 800		

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0 800	Continued From page 34 The findings include: On July 13, 2022, approximately from 11:00 a.m. to 12:15 p.m., survey staff toured the home with the program director (PD)-F. The licensed assisted living director(LALD)-A joined for parts of the tour. Survey staff observed the following findings during the tour: 1)The air conditioning unit was heavily layered with cottonwood and weed growth around the unit. The PD-F stated that they will take care of it. 2)The exterior wood window trims on the side of the house were deteriorating and with dark discoloration on the wood. 3) The windows located throughout the living room and the dining areas of the home had temporary clear plexiglass type of material along with temporary wood trim installed. The PD-F and the LALD-A explained that the windows were damaged by a previous resident and they were currently working with a contractor to have the windows replaced. 4)The garage floor was observed with some ponding of water. The garage floor had a floor drain in the middle but was not receiving water due to the improper pitch of the garage floor. Survey staff asked the PD-F about the ponding (standing) water on the garage floor but he was unclear on the cause. Upon further investigation, survey staff observed: -An indirect condensate piping next to the wall of the garage discharged onto the garage floor but the water ponded and did not make it to the floor drain of the garage. -Beneath the garage of the home was a storage room. The ceiling of the storage room was observed with the ceiling sagging in the middle of	0 800		

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0 800	Continued From page 35 the ceiling, and sweating and/or droplets of water in the ceiling from the standing water on the upper garage floor over time. -Mattresses, cardboard boxes, and wood studs were stored in the storage room and some items were damped due to the leakage from the garage floor. In addition, the wood stud showed signs of discoloration and potential mold growth. The PD-F verified the above findings as he explained that they will call a company to discard the mattress and other storage items. 5)The ceiling access panel in the garage was missing and therefore, comprised the fire separation between the garage and the home. 6) There was a significant number of weeds growing on top of the roof gutter visible from the front of the home indicating the gutter had not been cleaned out recently or was full of dirt/debris. The roof gutter must be cleaned out and maintained for proper roof drainage. 7) The egress window in resident room #4 was not easily accessible and operable as survey staff observed the PD-F opened the window with difficulty. Survey staff also observed that the windowsill was full of debris and spider web. 8) Containers of cleaning chemicals were observed in the lower-level bathroom that was accessible and posed safety concerns to the residents. All chemicals need to be stored in a secured room or closet to ensure the safety of residents. In addition, survey staff observed a "Raid Spray" in resident room #4 that needs to be secured and monitored for proper use. On July 13, 2022, at approximately 1:00 p.m. at the exit interview, the PD-F and LALD-A acknowledged the above findings. No Further information was provided.	0 800		

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0 800	Continued From page 36 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. (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.	0 810		

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0 810	Continued From page 37 This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to provide all required content on the fire safety and evacuation plan, the required training on fire safety and evacuation plan, and the minimum number of evacuation drills. This has the potential to directly affect the safety of all residents receiving care, 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 July 13, 2022, at approximately 12:15 p.m., survey staff received and reviewed the home's fire safety and evacuation documentation, the evacuation drill, and the training documentation. FIRE SAFETY AND EVACUATION PLAN 1) The plan documentation 9.06 (fire policy), dated "xx/xx/xxx", from Care Providers of Minnesota, incorrectly documented employee fire procedures for the home that included fire protection features such as "magnetic holders", "fire doors" and "smoke compartment doors" where they did not exist in the home. In addition, document review showed the plan lacked site-specific fire protection procedures necessary for addressing all residents including any unique resident-specific situations during an evacuation. Unique situations that must be considered during	0 810		

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0 810	Continued From page 38 an evacuation could be residents who have mobility limitations, cognitive impairment, or needing assistance during an evacuation and must be addressed in the fire safety and evacuation plan. 2)The plan documentation lacked fire protection procedures for residents. 3)The floor plan incorrectly showed the garage as an approved exit. TRAINING Documentation review showed the licensee lacked record of employee training on the fire safety and evacuation plan for the home. Survey staff explained that the fire safety and evacuation training was in addition to the required annual emergency preparedness plan training. The minimum required employee training is upon hire and twice a year. EVACUATION DRILLS Documented review of drill records indicated licensee failed to show compliance with the minimum number of required employee fire and evacuation drills performed to date for a minimum of two drills per year per shift with at least one drill every other month for a total minimum of six evacuation drills per year. The review of the drill records showed there were two employee drills performed to date, January 10, 2022, at 9:00 a.m. and May 15, 2022, at 2:00 p.m. No records were provided for the previous year. On July 13, 2022, at approximately 1:00 p.m. at the exit interview, the PD-F and the licensed assisted living director-A acknowledged the above findings. No further information was provided.	0 810		

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0 810	Continued From page 39 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 930 SS=C	144G.50 Subd. 2 (d-e; 1-4) Contract information (d) The contract must include a description of the facility's complaint resolution process available to residents, including the name and contact information of the person representing the facility who is designated to handle and resolve complaints. (e) The contract must include a clear and conspicuous notice of: (1) the right under section 144G.54 to appeal the termination of an assisted living contract; (2) the facility's policy regarding transfer of residents within the facility, under what circumstances a transfer may occur, and the circumstances under which resident consent is required for a transfer; (3) contact information for the Office of Ombudsman for Long-Term Care, the Ombudsman for Mental Health and Developmental Disabilities, and the Office of Health Facility Complaints; (4) the resident's right to obtain services from an unaffiliated service provider; This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to execute a written assisted living contract with the required content for two of two residents (R1, R2) with records reviewed. 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	0 930		

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0 930	Continued From page 40 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). The findings include: During the entrance conference on July 12, 2022, at approximately 12:15 p.m., the surveyor requested a copy of the resident agreement used by the licensee. Licensed assisted living director (LALD)-A provided what they stated was the current contract used by all residents. R1 and R2's contracts lacked the following content: -description of the assisted living facility's complaint resolution process, including the name and contact information of the person representing the facility who is designated to hand and resolve complaints. R1 On July 13, 2022, at approximately 8:55 a.m., the surveyor observed ULP-E administer medications to R1. R1's Resident Contract for Assisted Living, signed by R1 on July 2, 2022, lacked content listed above. R2 On July 13, 2022, at approximately 8:44 a.m., the surveyor observed ULP-E administer medications to R2. R2's Resident Contract for Assisted Living, signed by R2 on June 20, 2022, lacked content listed above.	0 930		

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0 930	Continued From page 41 On July 14, 2022, at approximately 10:43 a.m., licensed assisted living director (LALD)-A said he did not understand why "all was not there" in the contract or why it had things not allowed. LALD-A stated, regarding the contract language, he would have to check with the provider organization for some help. The licensee's 1.05 Signing an Assisted Living Contract policy, undated, indicated when a prospective resident decides to move into the facility, it requires an assisted living contract signed and received by the facility. The policy did not address the content of the contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 930		
0 940 SS=C	144G.50 Subd. 2 (e; 5-7) Contract information (5) a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including: (i) whether the facility is enrolled with the commissioner of human services to provide customized living services under medical assistance waivers; (ii) whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b); (iii) whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided;	0 940		

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0 940	Continued From page 42 (iv) whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required; (v) a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent; (vi) a statement that residents may be eligible for assistance with rent through the housing support program; and (vii) a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program; (6) the contact information to obtain long-term care consulting services under section 256B.0911; and (7) the toll-free phone number for the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to execute a written assisted living contract with the required content for two of two residents (R1, R2) with records reviewed. 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). The findings include:	0 940		

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0 940	Continued From page 43 During the entrance conference on July 12, 2022, at approximately 12:15 p.m., the surveyor requested a copy of the resident agreement used by the licensee. Licensed assisted living director (LALD)-A provided what they stated was the current contract used by all residents. R1's and R2's assisted living contracts lacked the following content: -a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including: -whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided; -whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required; -a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent; -a statement that residents may be eligible for assistance with rent through the housing support program; -a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program; and -the contact information to obtain long-term care consulting services under section 256B.0911. R1 On July 13, 2022, at approximately 8:55 a.m., the surveyor observed ULP-E administer medications to R1.	0 940		

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0 940	Continued From page 44 R1's Resident Contract for Assisted Living, signed by R1 on July 2, 2022, lacked content listed above. R2 On July 13, 2022, at approximately 8:44 a.m., the surveyor observed ULP-E administer medications to R2. R2's Resident Contract for Assisted Living, signed by R2 on June 20, 2022, lacked content listed above. On July 14, 2022, at approximately 10:43 a.m., licensed assisted living director (LALD)-A said he did not understand why "all was not there" in the contract or why it had things not allowed. LALD-A stated, regarding the contract language, would have to check with the provider organization for some help. The licensee's 1.05 Signing an Assisted Living Contract policy, undated, indicated when a prospective resident decides to move into the facility, it requires an assisted living contract signed and received by the facility. The policy did not address the content of the contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 940		
0 970 SS=F	144.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not	0 970		

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0 970	Continued From page 45 include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the facility's liability for health, safety, or personal property of a resident. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on July 12, 2022, at approximately 12:15 p.m., the surveyor requested a copy of the resident agreement used by the licensee. Licensed assisted living director (LALD)-A provided what they stated was the current contract used by all residents. The assisted living contract included two clauses that indicated the resident would waive the facility's liability for health, safety, or personal property of a resident. Page 15, section 27 titled "Indemnification," the contract indicated: Resident will indemnify and hold harmless landlord, its	0 970		

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0 970	Continued From page 46	0 970		

employees and agents from and against any and all claims, actions, damages and liability and expense in connection with loss of life, personal injury or damage to property, arising from or out of the use by resident of the rented premises or any other part of the landlord's property, or caused wholly or in part by an act or omission of resident or resident's guests or agents.

On page 16 of the contract, in the section titled "Liability," the contract indicated: Landlord is not liable to resident or resident's guests for any injury, death or property damage occurring in room or on provider's premises unless such injury, death or property damage occurs as a result of an equipment malfunction or hazardous condition within the building not caused by resident or resident's guests. Landlord is also not liable for any injury, death or damage occurring as the result of resident's receipt of health-related, supporting or other services from third part providers. Landlord may be liable to resident for its own negligent acts of those of its employee or agents. Unless caused by one of the aforementioned excepted reasons, resident agrees to hold landlord harmless from any and all claims for injuries, property damage or any other loss resulting from and accident or other occurrence in the room or on landlord's premises.

On July 14, 2022, at approximately 10:43 a.m., licensed assisted living director (LALD)-A said he did not understand why "all was not there" in the contract or why it had things not allowed. LALD-A stated, regarding the contract language, would have to check with the provider organization for some help.

The licensee's 1.05 Signing an Assisted Living Contract policy, undated, indicated when a

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0 970	Continued From page 47 prospective resident decides to move into the facility, it requires an assisted living contract signed and received by the facility. The policy did not address the content of the contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 970		
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 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	01370		

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01370	Continued From page 48	01370		

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 training was completed for one of one unlicensed personnel (ULP-E) to include all required content with employee records reviewed.

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:

ULP-E started employment on April 4, 2022.

On July 13, 2022, at approximately 8:55 a.m., the surveyor observed ULP-E administer medications to R1.

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01370	Continued From page 49 ULP-E's employee record lacked evidence of the following required skill area training: -reports of changes in the resident's condition to the supervisor designated by the assisted living provider; -medication, exercise and treatment reminders; -basic nutrition, meal preparation, food safety and assistance with eating; -preparation of modified diets as ordered by a licensed health professional; and -awareness of commonly used health technology equipment and assistive devices. On July 7, 2022, at approximately 12:07 p.m., registered nurse (RN)-B talked about ULP-E's missing training and said, "those skills were training which could be done on Educare" (computer-based training program). RN-B said the training was lacking for ULP-E and added they would have to get the training done. The licensee's 5.02 Competency Training Evaluations policy, undated, indicated the registered nurse must make certain the unlicensed personnel (ULP) are trained in the proper methods to perform tasks and are able to demonstrate the ability to competently follow procedures and perform tasks. The policy further indicated training and competency evaluation for all ULPs would include those listed above. 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	01380		

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01380	Continued From page 50 (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 training was completed for one of one unlicensed personnel (ULP-E) to include all required content with employee records reviewed. 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: ULP-E started employment on April 4, 2022.	01380		

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01380	Continued From page 51 On July 13, 2022, at approximately 8:55 a.m., the surveyor observed ULP-E administer oral medications to R1. ULP-E's employee record lacked evidence of the following required skill area training which included demonstrated competency. -range of motion and positioning; and -administering of medications as required. On July 13, 2022, at approximately 8:59 a.m., ULP-E told the surveyor she had been trained by the nurse to pass out medications and does that routinely when she works. ULP-E said she was given instruction both by reading, watching and then observing the pass medications and "then I had to show the nurse I was capable of passing medications." On July 7, 2022, at approximately 12:07 p.m., registered nurse (RN)-B talked about ULP-E's missing training and said, "those skills were training which could be done on Educare" (computer-based training program). RN-B said the nurse who trains each new staff keeps records of those trainings and added those records should be part of the employee's records. The licensee's 5.02 Competency Training Evaluations policy, undated, indicated the registered nurse must make certain the unlicensed personnel (ULP) are trained in the proper methods to perform tasks and are able to demonstrate the ability to competently follow procedures and perform tasks. The policy indicated training and competency evaluation for all ULPs would include those listed above. Further, the policy indicated a copy of all education, training and competency testing shall be kept in each employee's personnel file.	01380		

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01380	Continued From page 52 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380		
01440 SS=D	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure staff were supervised within 30 days after performing delegated nursing tasks for one of one	01440		

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01440	Continued From page 53 unlicensed personnel (ULP)-E with employee records reviewed. 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: During the entrance conference on July 12, 2022, at approximately 11:31 a.m., registered nurse (RN)-B stated unlicensed staff performed delegated tasks, including medication administration. ULP-E started employment on April 4, 2022. On July 13, 2022, at approximately 8:55 a.m., the surveyor observed ULP-E administer oral medications to R1. On July 13, 2022, at approximately 8:59 a.m., ULP-E told the surveyor she had been trained by the nurse to pass out medications and does that every day when she works. ULP-E's employee record lacked evidence the registered nurse supervised ULP-E within 30 days after performing delegated tasks. On July 14, 2022, at approximately 12:10 p.m., RN-B stated the supervision of ULP-E had not by done and confirmed there was no record of required 30-day observation in ULP-E's employee	01440		

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01440	Continued From page 54 records. The licensee's 6.17 Supervision of Staff - Delegated Services policy, undated, directed staff who provide delegated nursing or therapy tasks to resident will be supervised by an RN or appropriate licensed health professional to verify work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. The policy indicated direct supervision of staff performing delegated tasks must be provided within 30 days when the individual begins form for the licensee. The policy also indicated documentation of supervision activities will be retained in the employee's record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01440		
01460 SS=F	144G.63 Subdivision 1 Orientation of staff and supervisors 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. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to provide staff	01460		

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01460	Continued From page 55 orientation to assisted living licensing requirements and regulations for one of one employee (registered nurse (RN)-D) with employee records reviewed. This has the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: RN-D started employment on February 17, 2020, under the comprehensive home care license and began providing assisted living services on August 1, 2021. Review of resident and personnel records indicated RN-D conducted nursing assessments for the licensee's residents and provided training to the licensee's staff. RN-D's employee training record lacked evidence the RN was oriented to the new assisting living facility requirements to include: -overview of assisted living statutes; -review of providers' policies and procedures; -handling of emergencies and using emergency services; -reporting maltreatment of vulnerable adults or minors; -assisted living bill of rights; -handling of resident's complaints, reporting of complaints, where to report; -consumer advocacy services;	01460		

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01460	Continued From page 56 -review of the types of assisted living services the employee will provide and providers' scope of license; -principles of person-centered planning/service delivery; and -hearing loss training (optional). On July 14, 2022, at approximately 12:07 p.m., RN-B verified RN-D had no record of having completed orientation. RN-B said all staff are to have completed orientation and that needs to be in their files. RN-B and program manager (PM)-C said they were working to make sure staff completed all required training. The licensee's 5.01 Orientation of Staff and Supervisors & Content policy, undated, directed all staff providing and supervising direct services must complete an orientation to Assisted Living facility licensing requirements. The policy indicated the orientation must contain the topics identified above and evidence of completion of required orientation must be kept in each employee's record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	01460		
01470 SS=D	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff	01470		

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01470	Continued From page 57 person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated	01470		

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01470	Continued From page 58 age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employees received orientation to assisted living facility licensing requirements and regulations with all required content for one of two employees, (unlicensed personnel (ULP)-E) with employee records reviewed. This had potential to affect all four current residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at 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: During the entrance conference on July 12, 2022, at approximately 10:47 a.m., registered nurse (RN)-B stated "yes" she was familiar with the statutes and regulations for assisting living and added "we are getting to learn them more." Licensed assisted living director (LALD)-A, also present at the entrance, verified they held an	01470		

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01470	Continued From page 59 assisted living license under the new regulations, effective August 2021. ULP-E was hired April 4, 2022, to provide direct care services to the licensee's residents. On July 13, 2022, at approximately 8:55 a.m., the surveyor observed ULP-E administer medications to R1. ULP-E's training record lacked evidence the employee's orientation to assisting living facility requirements included: -an overview of the assisted living (144G) statutes; -introduction and review of all the provider's policies and procedures; -handling of resident complaints, reporting of complaints, where to report; -consumer advocacy services; -review of types of assisted living services the employee will provide and provider's scope of license; -principles of person-centered planning and care; and -hearing loss training (optional). On July 14, 2022, at approximately 12:07 p.m., RN-B said she did not know why ULP-E's orientation record was not complete. RN-B said all staff are to have completed orientation and that needs to be in their files. The licensee's 5.01 Orientation of Staff and Supervisors & Content policy, undated, directed all staff providing and supervising direct services must complete an orientation to Assisted Living facility licensing requirements. The policy indicated the orientation must contain the topics identified above. The policy also indicated	01470		

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01470	Continued From page 60 evidence of completion of required orientation must be kept in each employee record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	01470		
01530 SS=F	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (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; (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 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; This MN Requirement is not met as evidenced	01530		

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01530	Continued From page 61 by: Based on observation, interview and record review, the licensee failed to ensure staff received required dementia care training in the required time frame for two of two employees, (unlicensed personnel (ULP)-E and registered nurse (RN)-D) with employee records reviewed. This had the potential to affect all four current residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 finding include: ULP-E ULP-E was hired April 4, 2022, to provide direct care services to the licensee's residents. On July 13, 2022, at approximately 8:55 a.m., the surveyor observed ULP-E administer medications to R1. ULP-E's employee record did not indicate ULP-E completed 8 hours of required dementia training within 160 hours of the employee's start date. ULP-E's record indicated ULP-E completed no (zero hours) dementia training as of July 13, 2022. RN-D RN-D was hired February 17, 2020, to provide and supervise direct care services to the licensee's residents.	01530		

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01530	Continued From page 62 Review of resident and personnel records indicated RN-D conducted nursing assessments for the licensee's residents and provided training to the licensee's staff. RN-D's employee record lacked the required 8 hours of dementia-care training completed within 120 hours of the employee's start date. RN-D's record indicated RN-D completed only 3.25 hours of dementia training. During the exit conference on July 14, 2022, at approximately 12:11 p.m., the surveyor discussed the lack of dementia training for staff with RN-B, who verified required training was either incomplete or not done. RN-B stated this was a widespread issue and "we have to correct this across the board." The licensee's 5.03 Dementia Training policy, undated, indicated all staff are required to complete dementia training at the time of hire and annually thereafter. The policy indicated supervisors of direct care stall will complete eight hours of initial training within 120 of employment start date; and direct care staff will complete eight hours within 160 hours of employment start date. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
01610 SS=E	144G.70 Subd. 2 (a-b) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any services shall not be required to undergo an initial nursing	01610		

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01610	Continued From page 63	01610		

assessment.
(b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery.

This MN Requirement is not met as evidenced by:
Based on observation, interview and record review, the licensee failed to ensure a registered Nurse (RN) completed an initial assessment in the required time frame for two of two residents (R1, R2) with records reviewed.

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).

The findings include:

R1
R1 was admitted for services on July 1, 2021.

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01610	Continued From page 64 R1's diagnoses included anxiety disorder and mood disorder. On July 13, 2022, at approximately 8:39 a.m., the surveyor observed R1 receive a meal from unlicensed personnel (ULP)-E, which the resident consumed in her room. Later at about 8:55 a.m., ULP-E administered morning medications to R1. R1's record included an initial nursing assessment, using the uniform assessment tool, completed face-to-face by the registered nurse. R1's assessment was signed and dated by the RN on July 7, 2022, which was six days after R1 was admitted to the facility. Review of R1's nursing progress notes since admission provided no indication why the assessment was not completed timely. R2 R2 was admitted for services June 17, 2022. R2's diagnoses included mood disorder and anxiety. On July 13, 2022, at approximately 8:44 a.m., the surveyor observed ULP-E administer morning medications to R2 in the resident's room. R2's record included an initial nursing assessment, using the uniform assessment tool, completed face-to-face by the RN. R2's assessment was signed and dated by the RN on June 20, 2022, which was three days after R2 was admitted to the facility. Review of R2's nursing progress notes since the resident's admission provided no indication why	01610		

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01610	Continued From page 65 the assessment was not completed timely. On July 14, 2022, at approximately 12:11 p.m., RN-B said she was filling in for RN-D who was the nurse assigned for this facility and stated she did not know why R1 and R2's assessments were not completed timely. RN-B stated with this population, residents are often uncooperative with the nurse and it was difficult to gather information to complete assessments. RN-B also acknowledged that if a resident was not cooperative, there should be documentation in the notes about why an assessment was not completed. RN-B said she was aware of requirements for timing and when assessments needed to be done. The licensee's 6.01 Assessments, Reviews & Monitoring policy, undated, indicated a registered nurse would assess the physical and cognitive needs of prospective residents prior to the dated on which a prospective resident executes a contract with the facility or the date on which a prospective resident moves in, whichever is earlier. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01610		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must	01640		

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01640	Continued From page 66 include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure a current, written service plan was finalized no later than 14 calendar days after the date that services were first provided for one of two residents (R2) with records reviewed. 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:	01640		

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01640	Continued From page 67 R2 was admitted for services June 17, 2022. R2's diagnoses included mood disorder and anxiety. On July 12, 2022, at approximately 2:35 p.m., R2 talked about his stay at the assisted living facility. R2 said he moved in about a month ago and said the only services he received were meals, snacks and medications, and everything else he did by himself. R2 denied needing any help for dressing or bathing and stated he was "independent." R2 said he was pretty sure he did not have a service plan, "I don't think so." On July 13, 2022, at approximately 8:44 a.m., the surveyor observed ULP-E administer morning medications to R2 in the resident's room. R2's an initial nursing assessment dated June 20, 2022, indicated R2 needed no help with activities of daily living and was independent. A medication assessment summary dated June 20, 2022, indicated R2 was unable to safely self-administer medications, and medications were set up by the RN (registered nurse) and administered by staff. R2's record lacked a service plan. On July 13, 2022, at approximately 3:58 p.m., program manager (PM)-C verified the facility was providing medication management service to R2 and verified that R2 did not have a current service plan. PM-C said they were probably waiting on information about his funding before knowing what services they would be providing R2. Registered nurse (RN)-B, also present during the interview, said she was aware residents needed to have a service plan.	01640		

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01640	Continued From page 68 The licensee's 6.08 Service Plan policy, indicated all residents receiving assisted living services will have a service plan in place. The policy directed with 14 days after the date that services are first provided to a resident the licensee will finalize a written service plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency	01650		

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01650	Continued From page 69 medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the service plan included all required content for one of two residents (R1) with records reviewed. This had the potential to affect all four residents who received assisted living services from the licensee. 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: R1's diagnoses included anxiety disorder and mood disorder. On July 13, 2022, at approximately 8:39 a.m., the surveyor observed R1 receive a meal from unlicensed personnel (ULP)-E, which the resident consumed in her room. Later, at about 8:55 a.m., ULP-E administered morning medications to R1. R1's initial nursing assessment, dated July 7, 2022, indicated R1 needed no assistance with activities of daily living, ambulated and transferred independently and had no special dietary or oral care needs. R1's assessment indicated no	01650		

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01650	Continued From page 70 treatments. R1's medication management assessment, dated July 3, 2022, indicated R1 was unable to safely self-administer medications and the facility would provide medication management services. R1's service plan dated July 2, 2022, lacked the following content: -the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; -the identification of staff or categories of staff who will provide the services; -the schedule and methods of monitoring assessments of the resident; -the schedule and methods of monitoring staff providing services; and -a contingency plan that includes: -the action to be taken if the scheduled service cannot be provided; -information and a method to contact the facility; -the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and -the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. On July 13, 2022, at approximately 3:40 p.m., registered nurse (RN)-B confirmed R1's service plan was incomplete and did not include above noted content. RN-B stated this was a template	01650		

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01650	Continued From page 71 service plan that was used for all residents. The licensee's 6.08 Service Plan policy, indicated all residents receiving assisted living services will have a service plan in place. The policy indicated the service plan must include the items listed above. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650		
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed	01730		

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01730	Continued From page 72 personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop and maintain a current individualized medication management record for each resident to include all required content for two of two residents (R1, R2) with records reviewed. 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 is 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:	01730		

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01730	Continued From page 73 During the entrance conference on July 12, 2022, at 10:40 a.m., licensed assisted living director (LALD)-A and registered nurse (RN)-B confirmed the licensee provided medication management services to all residents at the facility. R1 R1's diagnoses included anxiety disorder and mood disorder. R1's Medication Assessment/Delegation form, dated July 3, 2022, indicated R1 was unable to safely self-administer medications. The form indicated R1 required medication management services including medication set up by nurse, administration by facility staff, weekly medication setup, ordering and storage of medications. R1's record lacked prescriber's orders. R1's medication administration record for July 2022, indicated R1 received: an anti-anxiety medication; two mood-stabilizers; two pain medications; a blood pressure medication; a muscle relaxant; and nicotine replacement gum. On July 13, 2022, at approximately 8:55 a.m., the surveyor observed ULP-E administer medications to R1. R1's medication management plan, undated, lacked: - documentation of specific resident instructions relating to the administration of medications; - identification of medication management tasks that may be delegated to ULP; - procedures for staff notifying an RN or appropriate licensed health professional when a problem arises with medication management services; - any resident-specific requirements relating to	01730		

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01730	Continued From page 74	01730		

documenting medication administration, verification that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions; and
- completion of medication reconciliation.

R2
R2's diagnoses included mood disorder and anxiety.

R2's Medication Assessment/Delegation form, dated June 20, 2022, indicated R2 required medication management services including medication set up by nurse, administration by facility staff, weekly medication setup, ordering and storage of medications.

R2's record lacked signed prescriber's orders. R2's medication administration record for July 2022, indicated R2 received: two anti-psychotic medications and one mood-stabilizer.

On July 13, 2022, at approximately 8:44 a.m., the surveyor observed ULP-E administer morning medications to R2 in the resident's room.

R2's record lacked a service plan or medication management plan to include a written statement of the medication management services the resident was provided. R2's medication management record lacked the following:
- a statement describing the medication management services that will be provided;
- documentation of specific resident instructions relating to the administration of medications;
- identification of medication management tasks that may be delegated to ULP;
- procedures for staff notifying an RN or appropriate licensed health professional when a

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01730	Continued From page 75 problem arises with medication management services; - any resident-specific requirements relating to documenting medication administration, verification that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions; and - completion of medication reconciliation. On July 14, 2022, at approximately 12:20 p.m., registered nurse (RN)-B said the medication management plans for both residents were not fully developed. RN-B stated they had the correct forms to use now and believed switching to an electronic record would help with organizing. The licensee's 7.03 Medication Management Individualized Plan policy, undated, indicated for each resident receiving medication management services, the licensee will prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The resident's individualized plan, based on the assessment, must include the items listed above. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01770 SS=D	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be	01770		

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01770	Continued From page 76 done at the time of setup. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure documentation of medication setup included all the required content for one of one resident (R2) with records reviewed 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: During the entrance conference on July 12, 2022, at 10:40 a.m., licensed assisted living director (LALD)-A and registered nurse (RN)-B confirmed the licensee provided medication management services to all residents at the facility. RN-B confirmed they provided medication set up for residents, including R2. R2 R2's diagnoses included mood disorder and anxiety. R2's Medication Assessment/Delegation form, dated June 20, 2022, indicated R2 required medication management services including medication set up by nurse, administration by facility staff, weekly medication setup, ordering and storage of medications.	01770		

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01770	Continued From page 77 R2's medication administration record for July 2022, indicated R2 received: two anti-psychotic medications and one mood-stabilizer. On July 13, 2022, at approximately 8:44 a.m., ULP-E removed R2's medications from a locked storage cupboard. R2's medications were already set up and stored in a medi-set (a plastic medication box with designated compartments for days and times). The surveyor observed ULP-E administer R2's medications in the resident's room. R2's record lacked documentation by the licensed nurse at the time of medication setup to include: documentation of the dates of medication setup, the name of the medication, quantity of dose, times to be administered, route of administration and the name of the person completing medication setup. R2's record included a document titled "Medication set up for [R2]" and it documented medication set up for the resident by the registered nurse (RN). The first entry read: Medication was set up for the week of June 17th through 23rd. Client's MAR (medication administration record) was followed as guide for this medication set up. Staff were educated to follow MAR as they administer these medications, will continue to monitor." There were four similar entries on the document, one each for successive weeks: June 24 through June 30; July 1 through July 7; and July 7 through July. None of the weekly entries were dated when written and only the last entry was signed by the RN. On July 14, 2022, at approximately 12:14 p.m., registered nurse (RN)-B explained when R2 was	01770		

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01770	Continued From page 78 admitted, the nurse documented the medication set-up for R2 on what the nurse described as a progress note. RN-B acknowledged the documentation lacked the required information. The licensee's 7.08 Medication Management -Administration and Setup policy, undated, indicated a licensed nurse would correctly and accurately document any medication setup provided. The documentation must include the medication name, strength, dosage, date and time of set up, method and route of administration. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01770		
01790 SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may	01790		

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01790	Continued From page 79	01790		

delegate this task to unlicensed personnel if:
(1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and
(2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address:
(i) the type of container or containers to be used for the medications appropriate to the provider's medication system;
(ii) how the container or containers must be labeled;
(iii) written information about the medications to be provided;
(iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information;
(v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative;
(vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and
(vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the

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01790	Continued From page 80 doses of each returned medication. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse developed written procedures for the unlicensed personnel (ULP) providing medications to residents having unplanned time away when the licensed nurse was not available. This had the potential to affect all four residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on July 12, 2022, at 10:40 a.m., licensed assisted living director (LALD)-A and registered nurse (RN)-B confirmed the licensee provided medication management services to all residents at the facility. The licensee's 7.10 Medication Management - Planned & Unplanned Time Away policy, dated August 1, 2021, indicated for unplanned resident time away when a pharmacist or licensed nurse was not available, the RN could delegate this task to ULP if the RN had developed written procedures for the ULP including any special instructions or procedures regarding controlled substances that were prescribed for the resident. The written procedure must address:	01790		

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01790	Continued From page 81 - the type of container or containers to be used for the medications appropriate to the provider's medication system; - how the container or containers must be labeled; - written information about the medications to be provided; - how the ULP must document in the resident's record that medications have been provided, including documenting the date the medications where provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; - how the RN would be notified that medications have been provided and whether the RN needs to be contacted before the medications are given to the resident or the designated representative; - a review by the RN of the completion of this task to verify that this task was completed accurately by the ULP; and - how the ULP must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each medication returned. During the exit conference on July 14, 2022, at approximately 12:15 p.m., RN-B and program manager (PM)-C said they were aware of the need for a procedure and need to competency test staff regarding resident leave of absence. RN-B provided no written procedure, stating, "we have not done this." RN-B also said there is no training or competency testing of staff for this procedure. No further information was provided.	01790		

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01790	Continued From page 82 TIME PERIOD FOR CORRECTION: Seven (7) days	01790		
01820 SS=E	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure written or electronically recorded prescriptions were obtained for two of two residents (R1, R2) who received medication management services with records reviewed. 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). The findings include: During the entrance conference on July 12, 2022, at approximately 10:40 a.m., licensed assisted living director (LALD)-A and registered nurse (RN)-B confirmed the licensee provided medication management services to all residents at the facility.	01820		

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01820	Continued From page 83 R1 R1's diagnoses included anxiety disorder and mood disorder. On July 14, 2022, at approximately 8:55 a.m., the surveyor observed ULP-E administer an as-needed medication, methocarbanmol (medication for muscle spasm/pain) 750 mg, to R1. R1's Medication Assessment/Delegation form, dated July 3, 2022, indicated R1 required medication management services including medication set up by nurse, administration by facility staff, weekly medication setup, ordering and storage of medications. R1's medication administration record for July 2022, indicated R1 received the following medications: hydroxyzine pamoate 25 mg (milligram); ibuprofen 600 mg (as needed); naproxen 500 mg (as needed); olanzapine 5 mg; meloxicam 7.5 mg; methocarbanmol 750 mg (as needed); Trazodone 50 mg; gabapentin 300 mg; and nicotine gum 2 mg. R1's record lacked prescriber orders for the medications. R2 R2's diagnoses included mood disorder and anxiety. R2's Medication Assessment/Delegation form, dated June 20, 2022, indicated R2 required medication management services including medication set up by nurse, administration by facility staff, weekly medication setup, ordering and storage of medications.	01820		

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01820	Continued From page 84 On July 13, 2022, at approximately 8:44 a.m., the surveyor observed ULP-E administer morning medications to R2 in the resident's room which included: aripiprazole 20 mg; divalproex sodium 500 mg; and olanzapine 5 mg. R2's record lacked signed prescriber orders for the medications. During the exit conference on July 14, 2022, at approximately 12:16 p.m., registered nurse (RN)-B acknowledged the lack of prescriber orders for R1 and R2 stating the residents were recent admissions and would get signed orders after they were seen by a primary doctor, and that has not happened. RN-B added many of the residents were homeless and did not have doctors, and it was often difficult to have orders at admission. RN-B acknowledged each resident needed to have orders for medications. The licensee's 7.20 Medication & Treatment Orders policy, undated, indicated the RN is responsible for assuring that current, authorized prescriber orders for medications or treatments administered by staff are kept on file in the resident's records. Further, an order for medication or treatment must be dated, signed by the prescriber and must be current and consistent with the resident's nursing assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		
01910 SS=D	144G.71 Subd. 22 Disposition of medications	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37197	A. BUILDING: _____ B. WING _____	07/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIQUE HOMES LLC	3940 46TH AVENUE NORTH ROBBINSDALE, MN 55422

(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
01910	Continued From page 85 (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure documentation of the disposition of medications included all required information for one of one discharged resident (R5) with record reviewed. 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).	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37197	A. BUILDING: _____ B. WING _____	07/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIQUE HOMES LLC	3940 46TH AVENUE NORTH ROBBINSDALE, MN 55422

(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
01910	Continued From page 86 The findings include: R5's Service Plan dated June 3, 2021, indicated R3 received medication administration services daily. R5's prescriber orders, dated June 15, 2021, indicated the resident received the following: an iron supplement, one blood pressure medication, five vitamin and mineral supplements, birth control pills and two anti-depressants. R5's discharge summary document, dated November 19, 2021, indicated R5 found a bigger space for the resident and resident's dog and was discharged to another facility. The document listed R5's medications, but lacked the medications' strengths, prescription numbers as appropriate, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. On July May 16, 2022, at approximately 12:15 p.m., registered nurse (RN)-B acknowledged R5's discharge paperwork had no record of the specific pills and quantity that were sent when the resident was discharged. RN-B said she did not know all this information was needed on the discharge record. The licensee's 7.23 Medication Disposal policy, undated, indicated the facility shall dispose of any medication remaining with the facility that are discontinued or expired or upon the termination of services contract according to state and federal regulations for disposition of medications and controlled substances. The policy indicated the facility must document the disposition of unused drugs and would include in the resident's record	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37197	A. BUILDING: _____ B. WING _____	07/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIQUE HOMES LLC	3940 46TH AVENUE NORTH ROBBINSDALE, MN 55422

(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
01910	Continued From page 87 the components listed above. No further information was provided. Time period for correction: Seven (7) days	01910		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors Subd. 8.Notice to visitors. (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to post a required notice with statutory language at the main entry of the facility to disclose electronic monitoring activity. This had the potential to affect all four current residents, staff and any visitors to the facility. 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). Findings include:	03090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37197	A. BUILDING: _____ B. WING _____	07/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIQUE HOMES LLC	3940 46TH AVENUE NORTH ROBBINSDALE, MN 55422

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03090	Continued From page 88 On July 12, 2022, at approximately 10:22 a.m., the surveyor entered the facility and observed no signage posted at the entrance or areas immediately adjacent to the entry regarding electronic monitoring. Registered nurse (RN)-B stated she knew residents could have cameras in their room but was not aware of the need for a sign about camera monitoring in the assisted living site. On July 12, 2022, at approximately 1:54 p.m. licensed assisted living director/owner (LALD)-A confirmed there was no signage posted regarding electronic monitoring. The licensee's 2.15 Electronic Monitoring policy, undated, indicated the licensee will support the use of electronic monitoring by residents and representatives as defined in the law. The policy indicated signs are installed at each facility entrance accessible to visitors that state: Electronic monitoring devices, including security cameras and audio devices, may be present to record persons or activities. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	03090		

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

Type: Full
Date: *07/12/22*
Time: 10:38:13
Report: 1024221128

Food and Beverage Establishment Inspection Report

Location:
Unique Homes Llc
3940 46th Avenue North
Robbinsdale, MN55422
Hennepin County, 27

Establishment Info:
ID #: 0038464
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 7632224909
ID #:

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

The following orders were issued during this inspection.

2-200 Employee Health

2-201.11C ** Priority 1 **

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

NO ILLNESS LOG PRESENTED AT TIME OF INSPECTION. SENT COPY VIA EMAIL. PRINT, MAINTAIN AND FILL OUT ACCORDINGLY.

Comply By: 07/12/22

4-700 Sanitizing Equipment and Utensils

4-702.11 ** Priority 1 **

MN Rule 4626.0900 Sanitize utensils and food contact surfaces of equipment before use, after cleaning.

PER PIC, SANITIZE OPTION IN DISHWASHING MACHINE IS NOT USED. ADVISED AND DISCUSSED TO WASH, RINSE AND SANITIZE UTENSILS AND EQUIPMENT PRIOR TO USE.

Comply By: 07/12/22

4-300 Equipment Numbers and Capacities

4-302.13B ** Priority 2 **

MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.

NO IRREVERSIBLE THERMOMETER OR TEMPERATURE TEST STRIPS AVAILABLE ON SITE TO TEST UTENSIL SURFACE TEMPERATURE OF DISHWASHING MACHINE. PROVIDE AND MAINTAIN.

Comply By: 07/12/22

2-100 Supervision

2-102.12AMN

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

NO CERTIFIED FOOD PROTECTION MANAGER CERTIFICATE ON SITE. SANITARIAN EXPLAINED PROCESS, ADVISED TO APPLY FOR CFPM AS SOON AS POSSIBLE. OBSERVED FOOD SAFETY COURSE (LEARN2SERVE) CERTIFICATE:
YVONNE NYATICH.
COMPLETED 4/6/2022.
000020271931

Comply By: 07/12/22

4-100 Equipment Construction Materials

4-101.17

MN Rule 4626.0490 Discontinue using wood and wood wicker as a food contact surface.

OBSERVED WOOD COOKING UTENSILS AND WOOD CUTTING BOARDS. ADVISED TO REPLACE WITH NON ABSORBENT MATERIAL. PIC (PERSON IN CHARGE) DISCARDED ITEMS ON SITE.

Comply By: 07/12/22

Food and Equipment Temperatures

Process/Item: Cold Holding/DELI MEAT
Temperature: 40 Degrees Fahrenheit - Location: WHIRLPOOL COOLER
Violation Issued: No

Process/Item: Cooling/MILK
Temperature: 43 Degrees Fahrenheit - Location: WHIRLPOOL COOLER
Violation Issued: No

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

DISCUSSED ALL ORDERS ON REPORT WITH NURSING EVALUATOR BRUCE MELCHER. ALSO DISCUSSED ALL ORDERS AND THE FOLLOWING WITH PROGRAM MANAGER, ETIMA KOLLIE:
- ALL ORDERS ON REPORT.
- EMPLOYEE ILLNESS LOG AND EXCLUSION POLICY.
- REPORTABLE DISEASES.
- HANDWASHING POLICY AND REVIEW.
- VOMIT AND FECAL MATTER CLEAN UP PROCEDURES.
- CFPM. ONE FULL-TIME EMPLOYEE PER ESTABLISHMENT REQUIRED TO HAVE CFPM.
- THERMOMETER USE.
- THERMOMETER CALIBRATION AND FREQUENCY.
- DATE MARKING AND DISCARD DATE.
- PROPER STACKING ORDER TO AVOID CROSS CONTAMINATION.
- PROPER TEMPERATURES FOR HOT AND COLD HOLDING, REHEATING, AND COOLING.
- USE DISHWASHING MACHINE SANITIZING OPTION.

Food and Beverage Establishment Inspection Report

KITCHEN IS RESIDENTIAL AND FOOD IS PREPARED FOR SAME-DAY SERVICE. OBSERVED INTACT LAMINATE FLOORING, INTACT AND SMOOTH CEILINGS AND WALLS. ALL WERE FOUND TO BE INTACT AND IN GOOD CONDITION AND WILL BE MONITORED AT FUTURE INSPECTIONS. IF AT SUCH TIME THESE ITEMS ARE FOUND TO BE A CONCERN OR RISK OF CONTAMINATION, ITEMS WILL BE ORDERED TO BE REPLACED AND BROUGHT UP TO CODE.

DISHWASHING MACHINE IS RESIDENTIAL HOWEVER HAS SANTIZING CYCLE OPTION.

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 1024221128 of 07/12/22.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/ /_____

Signed:_____

ETIMA KOLLIE
PROGRAM MANAGER

Signed:_____

Sheng Yang
Public Health Sanitarian I
Freeman Building
651-201-3985
sheng.yang@state.mn.us