Electronically delivered

March 8, 2022

Administrator
Brookdale West Saint Paul
305 Thompson Avenue East
West Saint Paul, MN 55118

RE: Project Number(s) SL30634015

Dear Administrator:

On February 15, 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 December 22, 2021. The follow-up evaluation determined your agency had not corrected all of the state licensing orders issued pursuant to the December 22, 2021 evaluation.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state licensing orders issued pursuant to the last evaluation completed on December 22, 2021, found not corrected at the time of the February 15, 2022, follow-up evaluation and/or subject to penalty assessment are as follows:

0580-Quality Management-144g.42 Subd. 2 = $500.00

The details of the violations noted at the time of this follow-up evaluation completed on February 15, 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 $500.00**. 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 Jonathan Hill at 651-201-3993.

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,

Jonathan Hill, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-201-3993 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
	30634	A. BUILDING: _____ B. WING _____	R 02/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE WEST ST PAUL AL	305 THOMPSON AVENUE EAST WEST SAINT PAUL, MN 55118

(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: Project # SL30634015 On February 15, 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 December 22, 2021. At the time of the survey, there were 12 residents receiving services under the Assisted Living Facility license. As a result of the revisit, the following orders were reissued: 0580, 0660, 1640, 1950, and 1960. The licensee is in substantial compliance with correction orders 0480 and 0810.	{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.A The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
{0 480} SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	{0 480}		

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{0 480}	Continued From page 1 (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: No further action required.	{0 480}		
{0 580} SS=F	144G.42 Subd. 2 Quality management 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.	{0 580}		

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{0 580}	Continued From page 2 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. This had the potential to affect all 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), 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 included: On February 15, 2022, at 1:00 p.m., the surveyor requested licensee's quality management plan to review, but no plan was provided by the licensee's executive director (ED)-A ED-A stated the licensee did not have a current quality management plan, as the corporate office is in process of redeveloping the plan to comply with Minnesota statutory requirements. No further information was provided.	{0 580}		
{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	{0 660}		

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{0 660}	Continued From page 3 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 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). The licensee failed to ensure a two-step tuberculin skin test (TST) was completed upon hire for one of two (unlicensed personnel (ULP)-F 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: The facility TB risk assessment was completed December 20, 2021, and indicated the facility was at a low risk for TB transmission. ULP-F was hired December 22, 2021, and	{0 660}		

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{0 660}	Continued From page 4 provided direct care services to licensee residents. ULP-F's record lacked documentation ULP-F completed a two step TST. On February 15, 2022, at 1:00 p.m., executive director (ED)-A confirmed ULP-F's employee record included a TB screening dated December 2, 2021, and a TST completed on May 25, 2021, (prior to hire) and read as negative on May 28, 2021. ULP-F's employee record lacked documentation ULP-F had a two-step TST completed by the licensee. The licensee's Facility Tuberculosis (TB) Risk Assessment Instructions and Worksheet for Health Care Settings Licensed by MDH, dated December 20, 2021, indicated baseline screenings at time of hire for all healthcare personnel would be completed by the licensee. No further information was provided.	{0 660}		
{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	{0 810}		

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{0 810}	Continued From page 5 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. This MN Requirement is not met as evidenced by: No further action required	{0 810}		
{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 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	{01640}		

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{01640}	Continued From page 6 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 interview and record review the licensee failed to ensure a service plan included a signature or other authentication by the facility and/or resident and/or representative 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: R2's service plans lack evidence R2 or licensee's representative signed R2's service plan. R2's Personal Service Plan dated November 18, 2021, indicated R2 received assistance with medication administration, and catheter care.	{01640}		

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{01640}	Continued From page 7 On February 15, 2022, at 1:00 p.m., executive director (ED)-A confirmed R2's service plan was not signed by R2 or licensee's representative. The licensee's Service Plan Process Policy dated August 2021, verified the resident or resident representative and members of the community care team that contributed to the service plan should sign the service plan. No further information was provided.	{01640}		
{01950} SS=D	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident 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 record; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by:	{01950}		

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{01950}	Continued From page 8 Based on observation, interview and record review, the licensee failed to ensure unlicensed personnel (ULP) completed catheter care for one of one resident (R2) 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). The findings include: R2's Personal Service Plan dated November 18, 2021, indicated R2 received assistance with medication administration, twice weekly shower assistance, and catheter care. R2's service plan indicated staff are to empty urine from the catheter bag each shift, keep the catheter bag lower than bladder, and to never leave the catheter bag on the floor for sanitation purposes. R2's physician orders dated February 4, 2022, directed staff to "change leg bag to overnight bag, Use alcohol swab to clean plastic tip before placing overnight bag on. Rinse leg bag with vinegar and hot water. Hang to dry in shower." In the morning, "change overnight leg bag. Use alcohol swab to clean plastic tip before placing leg bag on. Rinse overnight bag with vinegar and hot water. Hang to dry in shower." R2's physician orders dated February 4, 2022, directed staff to "change overnight bag to leg bag, Use alcohol swab to clean plastic tip before placing overnight bag on. Rinse leg bag with vinegar and hot water. Hang to dry in shower." In	{01950}		

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{01950}	Continued From page 9 the morning, "change overnight leg bag. Use alcohol swab to clean plastic tip before placing leg bag on. Rinse overnight bag with vinegar and hot water. Hang to dry in shower." On February 15, 2022, at 9:00 a.m., the surveyor observed observed R2 sitting in a chair in her apartment with a catheter bag hanging from the walker next to the chair. R2 stated she did not receive assistance from licensee's employees to empty the catheter bag. She stated she completed the catheter cares herself. R2 also verified staff did not offer to assist with changing the catheter bag to a leg bag during the day, or from a leg bag to the catheter bag at night, so the catheter bag was in place at all times. R2 stated an outside agency assists her with catheter cleaning and/or changes two times a week. On February 15, 2021, at 1:00 p.m. executive director (ED)-A stated she was not aware the ULP's did not provide R2's catheter cares and bag changes and indicated R2's services were checked off daily as completed by staff on R2's treatment record. On February 15, 2022, at 1:15 p.m., ULP-C stated R-2 will often refuse the bag changes and emptying, as R-2 prefers to complete the cares herself. ULP-C stated she will document the cares as completed on the treatment record as the cares were offered to R2. The licensee's Treatment or Therapy Management Services policy dated November 2018, verified "documentation of the services should be noted on the ADL sheet or Medication Administration Record (MAR/eMAR)/Treatment Administration Record (TAR/eTAR)."	{01950}		

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{01950}	Continued From page 10 No further information was provided.	{01950}		
{01960} SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to document treatment administration for one of one resident (R2) 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). The findings include: R2's Personal Service Plan dated November 18, 2021, indicated R2 received assistance with medication administration, twice weekly shower assistance, and catheter care. R2's service plan	{01960}		

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{01960}	Continued From page 11	{01960}		

indicated staff are to empty urine from the catheter bag each shift, keep urine bag lower than bladder, and to never leave the catheter bag on the floor for sanitation purposes.

R2's physician orders dated February 4, 2022, directed staff to "change leg bag to overnight bag, Use alcohol swab to clean plastic tip before placing overnight bag on. Rinse leg bag with vinegar and hot water. Hang to dry in shower." In the morning "change overnight leg bag. Use alcohol swab to clean plastic tip before placing leg bag on. Rinse overnight bag with vinegar and hot water. Hang to dry in shower."

R2's physician orders dated February 4, 2022, directed staff to "change overnight bag to leg bag, Use alcohol swab to clean plastic tip before placing overnight bag on. Rinse leg bag with vinegar and hot water. Hang to dry in shower." In the morning "change overnight leg bag. Use alcohol swab to clean plastic tip before placing leg bag on. Rinse overnight bag with vinegar and hot water. Hang to dry in shower."

On February 15, 2022, at 9:00 a.m., the surveyor observed R2 sitting in a chair in her apartment with a catheter bag hanging from the walker next to the chair. She stated she did not receive assistance from licensee's employees to empty the catheter bag. She stated she completed the catheter cares herself. R2 also verified staff did not offer to assist her with changing the catheter bag to a leg bag during the day, or from a leg bag to the catheter bag at night, so the catheter bag was in place at all times. R2 stated an outside agency assists her with catheter cleaning and/or changes two times a week.

On February 15, 2021, at 1:00 p.m., executive

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30634	A. BUILDING: _____ B. WING _____	R 02/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE WEST ST PAUL AL	305 THOMPSON AVENUE EAST WEST SAINT PAUL, MN 55118

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{01960}	Continued From page 12 director (ED)-A stated she was not aware the ULP's did not provide R2's catheter cares and bag changes, and indicated R2's services were checked off daily as completed on the treatment record. On February 15, 2022, at 1:15 p.m., ULP-C stated R-2 will often refuse the bag changes and emptying, as R2 preferred to complete the cares herself. ULP-C stated she would document the cares as completed on R2's treatment record as the cares were offered to R2. The licensee's Treatment or Therapy Management Services policy dated November 2018, verified "documentation of the services should be noted on the ADL sheet or Medication Administration Record (MAR/eMAR)/Treatment Administration Record (TAR/eTAR)." No further information was provided.	{01960}		

Electronically Delivered

January 25, 2022

Administrator
Brookdale West Saint Paul AL
305 Thompson Avenue East
West Saint Paul, MN 55118

RE: Project Number(s) SL30634015-0

Dear Administrator:

The Minnesota Department of Health completed an evaluation on December 22, 2021, 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, the following fines are assessed pursuant to this evaluation:

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program = $500.00

The total amount you are assessed is $500.00. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

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 surveys. 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:	Free from Maltreatment reconsideration requests should addressed to:

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

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

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.

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,

Jonathan Hill, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-201-3993 Fax: 651-215-9697

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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: SL30634015 On December 20, 2021, through December 22, 2021, 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 14 residents receiving 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.A The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 1 (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 ensure food was prepared and served according to the Minnesota Food Code. This had the potential to affect all fourteen (14) 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: Please refer to the included document titled Food	0 480		

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0 480	Continued From page 2 and Beverage Establishment Inspection Report, dated December 22, 2021, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) 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 ensure the assisted living facility established and maintained an infection control program that complied with accepted health care, medical and nursing standards related to infection control and COVID-19. 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	0 510		

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0 510	Continued From page 3 or has the potential to affect a large portion or all of the residents). The findings include: Employee and Visitor Screening On December 20, 2021, at 11:00 a.m., a visitor was observed to enter the building. The visitor was wearing a mask, and self-screened for COVID-19 symptoms. The screening did not include a temperature check. Minnesota Department of Health (MDH) guideline titled, COVID-19 Toolkit, Information for Long-Term Care Facilities, dated March 8, 2021, indicated as of March 8, 2021, staff and visitors must be screened for fever and symptoms of illness related to COVID-19. Screening included assessing for a fever, (measured temperature higher than 100 degrees Fahrenheit), or subjective fever (chills, feeling feverish), and asking about new symptoms of illness (measured or subjective fever, cough, shortness of breath, chills, headache, muscle pain, sore throat, or new loss of taste and smell). On December 22, 2021, at approximately 8:15 a.m., executive director (ED)-A confirmed visitors are screened upon entering the building with a self-screening procedure for COVID-19 symptoms. ED-A stated a sign is posted at the entrance for self screening directions, or, if unsure of procedure, to wait for a staff person to assist with screening prior to entering. ED-A confirmed a thermometer is not available to staff or visitors to complete a temperature check upon entrance. Hand Hygiene (HH) The licensee failed to ensure staff performed	0 510		

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0 510	Continued From page 4 hand hygiene according to the Centers for Disease Control and Prevention (CDC) and MDH guidelines. The CDC document titled, Interim Infection and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, updated December 14, 2020, indicated healthcare personnel (HCP) should perform hand hygiene (HH) before and after all patient contact, contact with potentially infectious material, and before donning and doffing personal protective equipment (PPE), including gloves. The CDC recommended alcohol-based hand sanitizer (ABHR) with 60% to 95% alcohol, or washing hands with soap and water for at least 20 seconds. On December 21, 2021, at 7:30 a.m., to 9:15 a.m., unlicensed personnel (ULP)-B was observed to provide personnel cares to residents. ULP-B did not perform HH before entering or providing cares to residents on four of five occurrences. On December 21, 2021, at 9:30 a.m., ULP-B stated the facility provided infection control and HH training. ULP-F verified she was trained to perform HH between residents. The licensee's Infection Prevention and Control Plan dated, August 2021, indicated "associates should perform hand hygiene before and after contact with the resident or the resident's environment." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		

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0 580 SS=F	144G.42 Subd. 2 Quality management 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. This had the potential to affect all 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), 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 included: On December 20, 2021, at 11:30 a.m. a request was made to review the licensee's quality management plan, but no plan was provided by the licensee.	0 580		

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0 580	Continued From page 6 On December 22, 2021, at 8:15 a.m., executive director (ED)-A stated the licensee did not have a current quality management plan, as the corporate office is in process of redeveloping the plan to comply with Minnesota statute requirements. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 580		
0 650 SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057.	0 650		

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0 650	Continued From page 7 (b) Each employee record must be retained for at least three years after a paid employee, volunteer, or contractor ceases to be employed by, provide services at, or be under contract with the facility. If a facility ceases operation, employee records must be maintained for three years after facility operations cease. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure employee records included all required content for one of two employees (unlicensed personnel (ULP)-B) 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-B was contracted on April 9, 2021, to provide direct care to the licensee's residents. On December 21, 2021, from 7:30 a.m., to 9:15 a.m. ULP-B was observed to provide cares to the licensee's residents to include dressing and grooming. ULP-B's employee record lacked evidence of a job description and orientation to each client. On December 22, 2021, at 10:25 a.m. the	0 650		

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0 650	Continued From page 8 executive director (ED)-A verified ULP-B's record lacked the above content. ED-A stated the ULP's were oriented to the residents upon hire, but verified the orientation was not included in the employee records. The licensee's Orientation and Annual Training policy dated August 2021, indicated "evidence of training of associates that perform direct Assisted living services should be kept in the associate personnel file," and would include orientation to the residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 660 SS=F	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	0 660		

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0 660	Continued From page 9 by: Based on interview, and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC). The licensee failed to ensure history and symptoms screening for active TB (either a two-step tuberculin skin test (TST) or blood test) was completed and documented for two of two employees (unlicensed personnel (ULP)-B, ULP-C) and a second step TST completed for ULP-C 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), 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 TB risk assessment was completed December 20, 2021, and indicated the facility was at a low risk for TB transmission. ULP-B was contracted on April 9, 2021, to periodically provide direct care to the licensee's residents. ULP-B's record lacked evidence of a completed TB symptom screening. ULP-C was hired November 18, 2020, and provided direct care services to licensee residents. ULP-C's record lacked evidence a TB symptom screening and second step of a two step TST was completed and included in the employee record.	0 660		

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0 660	Continued From page 10 On December 22, 2021, at 12:15 p.m. the executive director (ED)-A indicated the history and symptom screening for ULP-B and ULP-C should have been in the employee records, if completed, and was unsure if the second step TST was completed for ULP-C. The licensee's Facility Tuberculosis (TB) Risk Assessment Instructions and Worksheet for Health Care Settings Licensed by MDH, dated December 20, 2021, indicated annual symptom screening would be conducted on all healthcare workers, and baseline screenings at time of hire for all healthcare personnel would be completed by the licensee. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 730 SS=F	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health	0 730		

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0 730	Continued From page 11 records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident record included documentation of cares provided for one of two residents (R2) with records reviewed. This practice resulted in a level two violation (a	0 730		

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0 730	Continued From page 12 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: R2's records lacked daily documentation of cares and services provided. The licensee's December 2021, unlicensed personnel (ULP) assignment sheet indicated R2 required assistance with dressing cues, and catheter care and/or ostomy assistance. R2's December 2021, Activities of Daily Living (ADL) sheet indicated sleep checks every 4-6 hours, laundry, and morning cares were completed and documented on the night shift on December 1, 2, 4, 5, and 13, 2021. No additional documentation of cares provided on days, evenings, or night shift was included. In addition, the ADL sheet lacked documentation of ULP assistance with catheter care. On December 22, 2021, at 10:25 a.m. executive director (ED)-A verified no documentation of catheter care was completed by the ULP's, and daily documentation of cares provided for all residents was not regularly completed by the ULP's. The licensee's undated Portability of Training policy verified licensee staff received training in documentation requirements for services provided upon hire.	0 730		

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0 730	Continued From page 13 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730		
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	0 810		

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0 810	Continued From page 14 drill. This MN Requirement is not met as evidenced by: Based on observation interview and record review, the licensee failed to provide the required complete documentation on fire safety and evacuation plans and the required documentation on staff and resident training frequency related to evacuations. This has the potential to directly affect the safety of all residents receiving assisted living 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, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). On December 22, 2021, at approximately 12:50 p.m., survey staff received the facility fire safety and evacuation plan documentation, drills, and training records from director of maintenance (DM)-E for review. The findings include: 1. The fire safety and evacuation plan documentation lacked employee actions to be taken in the event of a fire or similar emergency, specific procedures for fire protection of residents, and employee actions to be taken in the event of a fire and fire protection procedures necessary for addressing all residents including any unique resident-specific situations during an evacuation especially for residents who were hearing or visually impaired, wheelchair-bound,	0 810		

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0 810	Continued From page 15 on walkers, and/or needing assistance during an evacuation. 2. No documentation of required training or records of training of employees on the facility's fire safety and evacuation plan to meet the minimum required training of twice a year, in addition, to the undated Critical Conversation Checklist the facility uses to train their new employee orientation training on emergency procedures including fire safety. 3. No documentation of required annual training of residents of once a year for residents that can self-assist in their evacuation on the proper actions to be taken in the event of a fire including movement, evacuation, or relocation. December 22, 2021, at approximately 1:45 p.m., (DM)-E acknowledged the findings during the documentation review discussion and interview. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (21) days	0 810		
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 person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section	01470		

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01470	Continued From page 16 626.557 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 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	01470		

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01470	Continued From page 17 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 include the required content, for two of two employees (unlicensed personel (ULP)-B and ULP-C) 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: ULP-B was contracted on April 9, 2021, ULP-A was hired on November 18, 2020, respectively, to provide direct assisted living services to the licensee's residents. Both employee records lacked orientation to home care requirements at the time of hire to include: -an overview of chapter 144G.08 through 144G.93; -an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; -the principles of person-centered planning and	01470		

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01470	Continued From page 18 service delivery and how they apply to direct support services provided by the staff person; -a review of the types of assisted living services the employee will be providing and the facility's category of licensure. On December 22, 2021, at 10:25 a.m. executive director (ED)-A stated the ULP's completed training online, and provided a course completion list for ULP-B and ULP-C; the list lacked the above required content. The licensee's Orientation and Annual Training policy dated August 2021, verified the above training topics would be included for all staff prior to providing Assisted Living services to residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty One (21) days	01470		
01640 SS=D	144G.70 Subd. 4 Service plan, implementation, and revisions t (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 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.	01640		

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01640	Continued From page 19 (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 interview and record review the licensee failed to ensure the service plan included a signature or other authentication by the facility and/or resident and/or representative 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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 and R2's service plans lack evidence the resident or licensee representative signed the service plans. R1's Personal Service Plan dated November 17, 2021, indicated R1 received assistance with medication administration, diabetes management, and twice weekly shower assistance. R2's Personal Service Plan dated November 18,	01640		

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01640	Continued From page 20 2021, indicated R2 received assistance with medication administration, catheter care, and assistance with dressing and grooming. On December 22, 2021, at 10:25 a.m. executive director (ED)-A confirmed R1 and R2's service plans were not signed by the resident or licensee representative. The licensee's Service Plan Process Policy dated August 2021, verified the resident or resident representative and members of the community care team that contributed to the service plan should sign the service plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration;	01940		

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01940	Continued From page 21 (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop a treatment management plan to include all required content and/or revised as needed for one of one resident (R2) 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). Physician orders dated November 22, 2021, directed to "change leg bag to overnight bag, Use alcohol swab to clean plastic tip before placing overnight bag on. Rinse leg bag with vinegar and hot water. Hang to dry in shower." In the morning "change overnight leg bag. Use alcohol swab to	01940		

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01940	Continued From page 22 clean plastic tip before placing leg bag on. Rinse overnight bag with vinegar and hot water. Hang to dry in shower." R2's Personal Service Plan dated November 18, 2021, indicated R2 received assistance with medication administration, twice weekly shower assistance, and catheter care. The service plan documented staff are to empty urine from bag each shift, and reminders to keep urine bag lower than bladder, and never left on the floor for sanitation purposes. The findings include: The licensee lacked a treatment and therapy management plan for catheter care to include: -documentation of specific resident instructions relating to the treatments or therapy administration -identification of treatment or therapy tasks that will be delegated to unlicensed personnel; -procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and -any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The unlicensed personnel (ULP) day shift care sheet indicated the ULP's assisted R2 with dressing-cues, catheter and/or ostomy assist. The care sheet lacked documentation of specific instructions for catheter care for R2. The December 2021 activities of daily living check off sheet of cares provided by the ULP's	01940		

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01940	Continued From page 23 lacked documentation of catheter care for R2. On December 22, 2021, at approximately 8:30 a.m., R2 was sitting in a chair in her apartment with a catheter bag hanging from the walker next to the chair. R2 stated she recently had the catheter placed at the hospital and she has been emptying the catheter herself since her return to the facility. On December 22, 2021, at 12:50 p.m. executive director (ED)-A verified R2 lacked a treatment and therapy plan for catheter care. ED-A stated the ULP's assisted R2 with catheter care, but did not document the cares provided. The licensee's Treatment or Therapy Management Services policy dated November 2018, indicated, "ULP should follow resident specific instructions for treatment(s) as indicated on Therapy or Treatment Management Plan and Delegated Tasks sheets. Documentation of the services should be noted on the ADL sheet or Medication Administration (MAR/eMAR)/Treatment Administration Record (TAR/eTAR)." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01950 SS=D	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be	01950		

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01950	Continued From page 24 delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident 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 record; 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 catheter care was completed by the unlicensed personnel (ULP) for one of one resident (R2) 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). The findings include: R2's Personal Service Plan dated November 18, 2021, indicated R2 received assistance with	01950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30634	A. BUILDING: _____ B. WING _____	12/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE WEST ST PAUL AL	305 THOMPSON AVENUE EAST WEST SAINT PAUL, MN 55118

(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
01950	Continued From page 25 medication administration, twice weekly shower assistance, and catheter care. The service plan indicated staff are to empty urine from bag each shift, contained reminders to keep urine bag lower than bladder, and to never leave on the floor for sanitation purposes. Physician orders dated November 22, 2021, directed to "change leg bag to overnight bag, Use alcohol swab to clean plastic tip before placing overnight bag on. Rinse leg bag with vinegar and hot water. Hang to dry in shower." In the morning "change overnight leg bag. Use alcohol swab to clean plastic tip before placing leg bag on. Rinse overnight bag with vinegar and hot water. Hang to dry in shower." On December 22, 2021, at approximately 8:30 a.m. R2 was sitting in a chair in her apartment with a catheter bag hanging from the walker next to the chair. R2 stated she recently had the catheter placed at the hospital and she has been emptying the catheter herself since her return to the facility. R2's record did not contain any specific written instructions from a RN related to R2's catheter care. On December 22, 2021, at 12:50 p.m. executive director (ED)-A confirmed R2 lacked a treatment plan for catheter care and lacked documentation of catheter cares provided by the ULPs. The licensee's Treatment or Therapy Management Services policy dated November 2018, verified "documentation of the services should be noted on the ADL sheet or Medication Administration Record (MAR/eMAR)/Treatment Administration Record (TAR/eTAR)."	01950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30634	A. BUILDING: _____ B. WING _____	12/22/2021

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01950	Continued From page 26 No further information was provided. TIME PERIOD OF CORRECTION: Seven (7) days	01950		
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to document treatment administration for one of one resident (R2) 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). The findings include:	01960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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BROOKDALE WEST ST PAUL AL	305 THOMPSON AVENUE EAST WEST SAINT PAUL, MN 55118

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01960	Continued From page 27 R2's Personal Service Plan dated November 18, 2021, indicated R2 received assistance with medication administration, twice weekly shower assistance, and catheter care. The service plan indicated staff were to empty urine from bag each shift, contained reminders to keep urine bag lower than bladder, and instruction to never leave on the floor for sanitation purposes. Physician orders dated November 22, 2021, direct to "change leg bag to overnight bag, Use alcohol swab to clean plastic tip before placing overnight bag on. Rinse leg bag with vinegar and hot water. Hang to dry in shower." In the morning "change overnight leg bag. Use alcohol swab to clean plastic tip before placing leg bag on. Rinse overnight bag with vinegar and hot water. Hang to dry in shower." On December 22, 2021, at approximately 8:30 a.m. R2 was sitting in a chair in her apartment with a catheter bag hanging from the walker next to the chair. R2 stated she recently had the catheter placed at the hospital and she has been emptying the catheter herself since her return to the facility. R2's record did not contain any specific written instructions from a RN related to R2's catheter care. On December 22, 2021, at 12:50 p.m., executive director (ED)-A confirmed R2 lacked a treatment plan for catheter care and lacked documentation of catheter cares provided by the ULP's. The licensee's Treatment or Therapy Management Services policy dated November 2018, verified "documentation of the services	01960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01960	Continued From page 28 should be noted on the ADL sheet or Medication Administration Record (MAR/eMAR)/Treatment Administration Record (TAR/eTAR)." No further information was provided. TIME PERIOD OF CORRECTION: Seven (7) days	01960		

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

Type: Full
Date: *12/22/21*
Time: 12:30:51
Report: 1021211382

Food and Beverage Establishment Inspection Report

Location:
Brookdale West St Paul
305 East Thompson
West St Paul, MN55118
Dakota County, 19

Establishment Info:
ID #: 0011662
Risk: Medium
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:
Brookdale Senior Living Commun

Phone #: 6514531803
ID #: 11571

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.

4-300 Equipment Numbers and Capacities

4-302.13B ***** Priority 2 *****

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

ESTABLISHMENT DOES NOT HAVE A MEASURING DEVICE THAT INDICATES THE FINAL UTENSIL SURFACE TEMPERATURE IN HIGH TEMPERATURE DISH MACHINE. PROVIDE AS DESCRIBED IN RULE ABOVE. THERMOLABELS WERE LEFT ON-SITE. SEE COMMENTS.

Comply By: 01/07/22

Surface and Equipment Sanitizers

Quaternary Ammonia: = 200PPM at Degrees Fahrenheit
Location: SANI BUCKET
Violation Issued: No

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

Final Utensil Surface Temp: = at 168 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 40 Degrees Fahrenheit - Location: MILK - TRUE UPRIGHT COOLER
Violation Issued: No

Food and Beverage Establishment Inspection Report

Process/Item: Cold Holding
Temperature: 41 Degrees Fahrenheit - Location: RICE - TRUE UPRIGHT COOLER
Violation Issued: No

Process/Item: Cooling
Temperature: 50 Degrees Fahrenheit - Location: EGG SALAD - TRUE UPRIGHT COOLER, COOLING FROM AMBIENT FOR LESS THAN 1 HR
Violation Issued: No

Process/Item: Cooking
Temperature: 193 Degrees Fahrenheit - Location: POTATOES - OVEN
Violation Issued: No

Process/Item: Cooking
Temperature: 192 Degrees Fahrenheit - Location: PORK - OVEN
Violation Issued: No

Process/Item: Cooking
Temperature: 165 Degrees Fahrenheit - Location: VEGETABLES - OVEN
Violation Issued: No

Process/Item: Cold Holding
Temperature: 40 Degrees Fahrenheit - Location: YOGURT - SUPERIOR UPRIGHT COOLER
Violation Issued: No

Process/Item: Cold Holding
Temperature: 39 Degrees Fahrenheit - Location: SHREDDED CHEESE - SUPERIOR UPRIGHT COOLER

Violation Issued: No

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

ALL FINDINGS ON THIS REPORT WERE DISCUSSED WITH DINING SERVICES COORDINATOR, ZONG XIONG AND HEALTH REGULATION DIVISION NURSE EVALUATORS, JOLENE BERTELSEN AND MARY BRUESS.

PER CONVERSATION WITH ZONG XIONG, FOOD IS MADE FOR SAME DAY SERVICE.

DISCUSSED EMPLOYEE ILLNESS POLICY AND RECORDING.

THE THERMOLABELS WILL HELP THE ESTABLISHMENT VERIFY THAT THEIR DISH MACHINE IS PROVIDING A FINAL UTENSIL SURFACE TEMPERATURE OF 160F OR ABOVE.

Food and Beverage Establishment Inspection Report

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Minnesota Department of Health inspection report number 1021211382 of 12/22/21.

Certified Food Protection Manager: VANG Z. XIONG

Certification Number: FM97488 Expires: 02/21/22

Inspection report reviewed with person in charge and emailed.

Signed: _____

ZONG XIONG
DINING SERVICES
COORDINATOR

Signed: _____

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

MINNESOTA

Employee Illness Log

- Employees are required to notify the person in charge (PIC) of their symptoms and pathogens that could cause foodborne illness.
- The PIC is required to record all reports of diarrhea or vomiting made by employees, and report the illness upon request.
- The PIC is required to notify the regulatory authority if any employees are known to be infected with ***Salmonella*, *Shigella*, Shiga toxin-producing *E. coli*, hepatitis A virus, norovirus, or another bacterial, viral or parasitic pathogen**.
- Minnesota Foodborne Illness Hotline: 1-877-Food-ILL (1-877-366-3455)

Report date	Employee name	Vomiting*	Diarrhea*	Jaundice	Fever	Respiratory (cough, sore throat, runny nose)	Comments or additional symptoms	Date returned to work	Diagnosed with a pathogen? (see list above)	If diagnosed, 1-877-FOOD-ILL or local health agency contacted?
6/12/2019	*John Doe*	*X*	*X*				*Sent home*	*6/15/2019*	*Yes – norovirus*	*Yes*

***Employees with diarrhea or vomiting CANNOT RETURN TO WORK for at LEAST 24 HOURS after symptoms end.**

Resources

Minnesota Department of Health Food Business Safety (www.health.state.mn.us/foodbizsafety)

Minnesota Department of Health
Food, Pools, and Lodging Services
PO Box 64975
St. Paul, MN 55164-0975
651-201-4500
health.foodlodging@state.mn.us
www.health.state.mn.us

Minnesota Department of Agriculture
Food and Feed Safety Division
625 Robert Street N
St. Paul, MN 55155-2538
651-201-6027
MDA.FFSD.Info@state.mn.us
www.mda.state.mn.us

MARCH 2019

To obtain this information in a different format, call: 651-201-4500 or 651-201-6000. Printed on recycled paper.