



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

March 8, 2024

Licensee
Serendipitous Living
7935 Upper 139th Court West
Apple Valley, MN 55124

RE: Project Number(s) SL37368015

Dear Licensee:

On February 28, 2024, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on October 4, 2023. This follow-up survey determined your facility had corrected all of the state correction orders issued pursuant to the October 4, 2023 survey.

Also, at the time of this follow-up survey completed on February 28, 2024, we identified the following violation(s):

0690-Resident Record-144g.43 Subdivision 1

The details of the violation(s) noted at the time of this follow-up survey are delineated on the attached State Form. Only the ID Prefix Tag in the left hand column without brackets will identify these state correction 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), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

CORRECTION ORDER RECONSIDERATION PROCESS

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

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

To submit a reconsideration request, please visit:

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

We urge you to review these orders carefully. If you have questions, please contact Jodi Johnson at 507-344-2730 .

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

Sincerely,

A handwritten signature in black ink, appearing to read "Jodi Johnson", with a long horizontal flourish extending to the right.

Jodi Johnson, Supervisor
State Evaluation Team
Email: jodi.johnson@state.mn.us
Telephone: 507-344-2730 Fax: 1-866-890-9290

PMB

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37368	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 02/28/2024
NAME OF PROVIDER OR SUPPLIER SERENDIPITOUS LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 7935 UPPER 139TH COURT WEST APPLE VALLEY, MN 55124			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
{0 000}	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(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: SL37368015-2 On February 26, 2024, through February 28, 2024, the Minnesota Department of Health conducted a revisit at the above provider to follow up on orders issued pursuant to a survey completed on October 4, 2023, and December 26, 2023. At the time of the survey, there were five residents; five receiving services under the Assisted Living license. As a result of the revision, the following orders were issued/reissued.	{0 000}	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.		
{0 480} SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the	{0 480}			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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{0 480}	Continued From page 1 following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: No further action needed	{0 480}			
0 690 SS=F	144G.43 Subdivision 1 Resident record (a) Assisted living facilities must maintain records for each resident for whom it is providing services. Entries in the resident records must be current, legible, permanently recorded, dated, and authenticated with the name and title of the person making the entry. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure entries in four of four residents records (R1, R4, R5, and R6) were authenticated by the name and title of the person making the entry. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1	0 690			

Minnesota Department of Health

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0 690	Continued From page 2 R1's diagnoses included seizure disorder, diabetes (disease that affects how the body uses blood sugar), and moderate mental retardation (cognitive deficits in functional and adaptive skills). R1's daily resident log dated February 2024, indicated R1 received the following services: -bathing -dressing -toileting -wash hair -mouth care, partial teeth -style hair, combing, brushing -apply lotion -nail care and foot care -meals -housekeeping -transportation -ambulation The above tasks were marked complete by the unlicensed personnel (ULP) with a check mark. The daily log lacked authentication of the person making the entry. R4 R4's diagnoses included cerebrovascular accident (stroke) with left hemiplegia (paralysis of one side of the body) and dysphagia (difficulty swallowing). R4's daily resident log dated February 2024, indicated R4 received the following services: -bathing -dressing -toileting -wash hair -mouth care -style hair, combing, brushing	0 690			

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0 690	Continued From page 3 -apply lotion -nail care and foot care -meals -housekeeping -transportation -ambulation The above tasks were marked complete by the ULP with a check mark. The daily log lacked authentication of the person making the entry. R5 R5's diagnoses included seizure disorder. R5's daily resident log dated February 2024, indicated R5 received the following services: -bathing -dressing -toileting -wash hair -mouth care, partial teeth -style hair, combing, brushing -apply lotion -nail care and foot care -meals -housekeeping -transportation -ambulation The above tasks were marked complete by the ULP with a check mark. The daily log lacked authentication of the person making the entry. R6 R6's diagnoses included bipolar disorder (disorder associated with episodes of mood swings ranging from depressive lows to manic highs). R6's daily resident log dated February 2024,	0 690			

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0 690	Continued From page 4 indicated R6 received the following services: -bathing -toileting -wash hair -mouth care, partial teeth -style hair, combing, brushing -apply lotion -nail care and foot care -meals -housekeeping -transportation -ambulation The above tasks were marked complete by the ULP with a check mark. The daily log lacked authentication of the person making the entry. On February 28, 2024, at 10:30 a.m. owner (O)-G stated the daily resident logs for all residents lacked authentication by the name and title of the person making the entry. The licensee's Resident Records policy, undated, indicated all entries into the clinical record would be legible, permanently recorded in ink, dated, and authenticated with the name and title of the person making the entry. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 690			
{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:	{0 780}			

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{0 780}	Continued From page 5 (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: No further action needed	{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	{0 790}			

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{0 790}	Continued From page 6 maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: No further action needed	{0 790}			
{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	{0 810}			

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{0 810}	Continued From page 7 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 needed	{0 810}			



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January 8, 2024

Licensee
Serendipitous Living
7935 Upper 139th Court West
Apple Valley, MN 55124

RE: Project Number(s) SL37368015

Dear Licensee:

On December 26, 2023, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on October 4, 2023. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the October 4, 2023 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on October 4, 2023, found not corrected at the time of the December 26, 2023, follow-up survey and/or subject to penalty assessment are as follows:

- 0470-Minimum Requirements-144g.41 Subdivision 1 - \$500.00**
- 0480-Minimum Requirements-144g.41 Subd 1 (13) (i) (b) - \$500.00**
- 0660-Tuberculosis Prevention And Control-144g.42 Subd. 9 - \$500.00**
- 0680-Disaster Planning And Emergency Preparedness-144g.42 Subd. 10 - \$500.00**
- 0730-Contents Of Resident Record-144g.43 Subd. 3 - \$500.00**
- 1290-Background Studies Required-144g.60 Subdivision 1 - \$500.00**
- 1370-Training And Evaluation Of Unlicensed Personnn-144g.61 Subd. 2 (a)**
- 1500-Required Annual Training-144g.63 Subd. 5**
- 1640-Service Plan, Implementation And Revisions To-144g.70 Subd. 4 (a-E)**
- 1650-Service Plan, Implementation And Revisions To-144g.70 Subd. 4 (f) - \$500.00**
- 1710-Individualized Medication Monitoring And Reas-144g.71 Subd. 3**
- 1730-Individualized Medication Management Plan-144g.71 Subd. 5**
- 1790-Medication Management For Residents Who Will-144g.71 Subd. 10 - \$500.00**
- 1880-Storage Of Medications-144g.71 Subd. 19 - \$500.00**
- 1940-Individualized Treatment Or Therapy Managemen-144g.72 Subd. 3**

The details of the violations noted at the time of this follow-up survey completed on December 26, 2023 (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 survey completed on December 26, 2023, we identified the following violation(s):

0340-Correction Orders-144g.30 Subd. 5 - \$500.00

1960-Documentation Of Administration Of Treatments-144g.72 Subd. 5

The details of the violation(s) noted at the time of this follow-up survey are delineated on the attached State Form. Only the ID Prefix Tag in the left hand column without brackets will identify these state correction 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 \$5,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

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

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 may challenge the correction order(s) issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by the MDH within 15 calendar days of the correction order receipt date.

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

To submit a reconsideration request, please visit:

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

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has

been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. to submit a hearing request, please visit:

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

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

We urge you to review these orders carefully. If you have questions, please contact Jodi Johnson at 507-344-2730.

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

Sincerely,

A handwritten signature in black ink, appearing to read "Jodi Johnson", with a stylized flourish at the end.

Jodi Johnson, Supervisor
State Evaluation Team
Email: jodi.johnson@state.mn.us
Telephone: 507-344-2730 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

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{0 000}	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: Project # SL37368015-1 On December 26, 2023, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on October 4, 2023. At the time of the survey, there were five active 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 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.		
0 340 SS=F	144G.30 Subd. 5 Correction orders a) A correction order may be issued whenever the commissioner finds upon survey or during a	0 340			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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0 340	Continued From page 1 complaint investigation that a facility, a managerial official, an agent of the facility, or an employee of the facility is not in compliance with this chapter. The correction order shall cite the specific statute and document areas of noncompliance and the time allowed for correction. (b) The commissioner shall mail or email copies of any correction order to the facility within 30 calendar days after the survey exit date. A copy of each correction order and copies of any documentation supplied to the commissioner shall be kept on file by the facility and public documents shall be made available for viewing by any person upon request. Copies may be kept electronically. (c) By the correction order date, the facility must document in the facility's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the facility's action to respond to the correction order in future surveys, upon a complaint investigation, and as otherwise needed. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have sufficient documentation with actions taken to comply with the correction orders for a revisit survey completed on December 26, 2023. 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	0 340			

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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
0 340	Continued From page 2 has affected or has the potential to affect a large portion or all of the residents). The findings include: During the revisit survey on December 26, 2023, a review of the licensee's policies and procedures, resident records, and employee records, lacked evidence to indicate the licensee had attempted to correct all the orders issued for the survey concluded on October 4, 2023. Reissued orders include: 0470, 0660, 0680, 0730, 1290, 1370, 1500, 1640, 1650, 1710, 1730, 1790, 1880 and 1940. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 340			
{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	{0 470}			

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{0 470}	Continued From page 3 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 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 residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee held and assisted living license. The facility was licensed for a capacity of five and had a current census of five residents. On December 26, 2023, at 9:30 a.m., licensed assisted living director/registered nurse (LALD/RN)-A stated the licensee had not developed a staffing plan.	{0 470}			

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{0 470}	Continued From page 4 No further information was provided.	{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: (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 needed	{0 480}			
{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 by: Based on interview and record review, the	{0 660}			

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{0 660}	Continued From page 5 licensee failed to maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included documentation of a completed health history and symptom screening for three of three employees (unlicensed personnel (ULP)-B, ULP-C and ULP-D). This had the potential to affect all residents, staff and visitors of the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-B ULP-B was hired September 15, 2019, to provide direct care and services to the facility's residents. ULP-B's employee record contained a negative QuantiFERON test dated October 24, 2023; however, ULP-B's employee record lacked evidence of the following: - TB history and symptom screening ULP-C ULP-C was hired on January 31, 2019, to provide direct care and services to the facility's residents. ULP-C's employee record contained a negative QuantiFERON test dated October 20, 2023; however, ULP-C's employee record lacked evidence of the following:	{0 660}			

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{0 660}	Continued From page 6 - TB history and symptom screening ULP-D was hired on May 30, 2019, to provide direct care and services to the facility's residents. ULP-D's employee record contained a negative Quantiferon test dated December 6, 2023; however, ULP-D's employee record lacked the following: -TB history and symptom screening On December 26, 2023, at 1:00 p.m. licensed assisted living director/registered nurse (LALD/RN)-A stated ULP-B, ULP-C and ULP-D's employee records were missing the TB history and symptom screening. The licensee's Tuberculosis Prevention and Screening Plan policy, undated, indicated staff would be assessed for current symptoms of active TB disease and would be tested for the presence of infection with Mycobacterium tuberculosis by administering either a two-step TST or single TB blood test. It further indicated the licensee would complete a risk assessment every two years or sooner when appropriate. 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	{0 680}			

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{0 680}	Continued From page 7 emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post an emergency disaster plan prominently, have a written emergency preparedness (EP) plan with all the required content. This had the potential to affect all residents, staff, and visitors of the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include:	{0 680}			

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{0 680}	Continued From page 8 EMERGENCY PLAN POSTED On December 26, 2023, at approximately 9:25 a.m. upon entering the facility, the surveyor did not observe any signage or information regarding the licensee's emergency disaster or preparedness plan posted. At this time, licensed assisted living director/registered nurse (LALD/RN)-A stated the plan was not posted prominently. EMERGENCY PREPAREDNESS PLAN (EPP) CONTENT The licensee's Emergency Preparedness plan, undated, was reviewed and lacked the following: - establish and maintain a comprehensive EPP, reviewed/updated annually; - how they would coordinate with other health care facilities and community during an emergency or disaster (natural, man-made, facility, etc.), reviewed/updated annually; - documented date of reviews and updates; - community risk assessment with documentation; - consider duration of interruptions; - arrangements/contracts to re-establish utility services; - develop strategies for addressing community-based risks (evacuation plans, staffing/shortage, back-up plans); - an assessment of at-risk population's needs including maintaining independence, communication, transportation, supervision, and medical care; - must identify which staff would assume specific roles in another's absence through succession planning and delegation of authority; - a qualified person who is authorized, in writing, to act in the absence of the administrator; - a process for cooperation and collaboration with local, tribal, regional, State and Federal EP to	{0 680}			

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{0 680}	Continued From page 9 maintain integrated response; - develop and implement EP policies/procedures and review/update annually; - develop/implement EP policies and procedures to address evacuation and shelter in place for staff and residents which must include: - alternate sources of energy to maintain temperature, safety and sanitary storage of provisions; - alternate sources of energy to fire detection, extinguishing, alarms systems; - a tracking system used to document locations of residents, staff, and relocation of staff; - develop policies and procedures to address safe evacuation from the facility including: - needs of evacuees; - staff responsibilities; - transportation; - alternate communication means; - develop policy and procedures for shelter in place for residents, staff and volunteers who remain at the facility; - develop policy and procedures to address: - systems of medical documentation that preserve resident information; - protects confidentiality; - secures/maintains availability of records; - develop policy and procedures must address use of volunteers including process and role for integration; - develop policy and procedures which address development and arrangements with other facilities or providers to receive residents in the event continuity of services cannot be provided; - develop a written communication plan and review/update annually; - communication plan must include all the following names/contact information: - entities providing services under	{0 680}			

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{0 680}	Continued From page 10 agreement; - residents' physicians; - volunteers; - communication plan must include contact information for: - other sources of assistance; - communication plan must include: - means to provide information about facility occupancy; - and ability to provide assistance; - authority having jurisdiction; - incident Command Center; - or designee; - communication plan must include a method for sharing information from emergency plan; - must develop and maintain EP training and testing program, review/update annually; - must conduct exercises to test the EP plan at least twice per year including unannounced staff drills using the EP; - must implement emergency and standby power systems based on their EP; and - if part of a healthcare system consisting of separately certified healthcare facilities and elects to have a unified and integrated EP, they may choose to participate. On December 26, 2023, at 1:02 p.m. LALD/RN-A stated the licensee's current EP plan did not include the above content. LALD/RN-A further stated the licensee's owner was the one responsible for updating this document. The licensee's Emergency Preparedness policy, undated, indicated the licensee would have an identified plan in place to assure the safety and well-being of clients and staff during periods of an emergency disaster that disrupts services. No additional information was provided.	{0 680}			

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{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 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;	{0 730}			

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{0 730}	Continued From page 12 (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 the required documentation of all provided services for two of two residents (R1, R3). 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 R1's start of care was February 1, 2019, with diagnoses including seizure disorder, diabetes (disease that affects how the body uses blood sugar), and moderate mental retardation (cognitive deficits in functional and adaptive skills). R1's service plan dated November 1, 2023, indicated R1 received assistance with bathing, dressing, toileting, transfers, housekeeping, laundry, meals, and medication management.	{0 730}			

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{0 730}	Continued From page 13 R1's record lacked documentation that services were provided as scheduled. R3 R3's start of care was July 15, 20219, with diagnoses including diabetes (disease that affects how the body uses blood sugar), and hypertension (high blood pressure). R3's service plan dated November 1, 2023, indicated R3 received assistance with bathing, grooming, dressing, housekeeping, laundry, meals, medication management and once daily blood sugar checks. R3's record lacked documentation that services were provided as scheduled. On December 26, 2023, at 11:19 a.m. licensed assisted living director/registered nurse (LALD/RN)-A stated staff did not document assistance with activities of daily living for any of the residents. LALD/RN-A further stated he was working on creating a document for the staff to document services provided, but it had not been implemented yet. The licensee's Resident Record policy, undated, indicated the resident record would contain documentation of services provided as identified in the service plan. No further information was provided.	{0 730}			
{0 780} SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with	{0 780}			

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{0 780}	Continued From page 14 the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: No further action needed	{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,	{0 790}			

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{0 790}	Continued From page 15 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: No further action needed	{0 790}			
{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	{0 810}			

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{0 810}	Continued From page 16 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 needed	{0 810}			
{01290} SS=F	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 by: Based on interview and record review, the licensee failed to ensure a background study was affiliated with the assisted living facility (ALF) license for three of three employees (unlicensed personnel (ULP)-B, ULP-C and ULP-D). This had	{01290}			

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NAME OF PROVIDER OR SUPPLIER SERENDIPITOUS LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 7935 UPPER 139TH COURT WEST APPLE VALLEY, MN 55124		
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{01290}	Continued From page 17 the potential to affect all residents living in the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-B ULP-B was hired on September 15, 2019, to provide direct care and services to the facility's residents. ULP-B's employee record contained a Background Study Clearance dated September 6, 2019, from a sister facility. However, the document was not affiliated with the facility's license. ULP-C ULP-C was hired on January 31, 2019, to provide direct care and services to the facility's residents. ULP-C's employee record contained a Background Study Clearance dated March 18, 2020, from a sister facility. However, the document was not affiliated with the facility's license. ULP-D ULP-D was hired on May 30, 2019, to provide direct care and services to the facility's residents.	{01290}			

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{01290}	Continued From page 18 ULP-D's employee record contained a Background Study Clearance dated April 20, 2019, from a sister facility. However, the document was not affiliated with the facility's license. On December 26, 2023, at 11:58 a.m. licensed assisted living director/registered nurse (LALD/RN)-A stated ULP-B, ULP-C and ULP-D's background study were not affiliated with the current ALF. The licensee's Employee Record policy, undated, indicated each employee record would have documentation of a background study and fingerprints as required. No further information was provided.	{01290}			
{01370} SS=E	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;	{01370}			

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{01370}	Continued From page 19 (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 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 interview and record review, the licensee failed to ensure training and competency was completed for three of three employees (unlicensed personnel (ULP)-B, ULP-C, and ULP-D) to include all required content. 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).	{01370}			

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{01370}	Continued From page 20 The findings include: ULP-B ULP-B was hired on September 15, 2019, to provide direct care and services to the facility's residents. ULP-B's employee record lacked evidence of competency evaluations for the following topics: - appropriate and safe techniques in personal hygiene and grooming, including: - hair care and bathing - care of teeth, gums and oral prosthetic devices - care and use of hearing aids - dressing and assisting with toileting - standby assistance techniques and how to perform them - reading and recording temperature, pulse, and respirations of the client - safe transfer techniques and ambulation - range of motion and positioning - administering medications or treatments as required ULP-C ULP-C was hired on January 31, 2019, to provide direct care and services to the facility's residents. ULP-C's employee record lacked evidence of competency evaluations for the following topics: - appropriate and safe techniques in personal hygiene and grooming, including: - hair care and bathing - care of teeth, gums and oral prosthetic devices - care and use of hearing aids - dressing and assisting with toileting - standby assistance techniques and how to	{01370}			

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{01370}	Continued From page 21 perform them - reading and recording temperature, pulse, and respirations of the client - safe transfer techniques and ambulation - range of motion and positioning - administrating medications or treatments as required ULP-D ULP-D was hired on May 30, 2019, to provide direct care and services to the facility's residents. ULP-D's employee record lacked evidence of competency evaluations for the following topics: - appropriate and safe techniques in personal hygiene and grooming, including: - hair care and bathing - care of teeth, gums and oral prosthetic devices - care and use of hearing aids - dressing and assisting with toileting - standby assistance techniques and how to perform them - reading and recording temperature, pulse, and respirations of the client - safe transfer techniques and ambulation - range of motion and positioning - administrating medications or treatments as required On December 26, 2023, at 12:56 p.m. licensed assisted living director/registered nurse (LALD/RN)-A stated ULP-B, ULP-C, and ULP-D were trained and competent in all the areas listed above, but the competencies listed above were not documented. The licensee's Staff Orientation and Education policy, undated, indicated all employees would attend and complete general orientation and	{01370}			

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{01370}	Continued From page 22 those providing direct services would complete a competency evaluation as part of the orientation process. No further information was provided.	{01370}			
{01500} SS=E	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and	{01500}			

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{01500}	Continued From page 23 (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the 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 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 annual training included all required topics for each 12 months of employment for three of three employees (unlicensed personnel (ULP)-B, ULP-C and ULP-D). 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	{01500}			

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{01500}	Continued From page 24 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: ULP-B ULP-B was hired on September 15, 2019, to provide direct care and services to the facility's residents. ULP-B's employee record lacked evidence the employee had successfully completed annual training as required, to include the following: - Assisted Living bill of rights ULP-C ULP-C was hired on January 31, 2019, to provide direct care and services to the facility's residents. ULP-C's employee record lacked evidence the employee had successfully completed annual training as required, to include the following: - Assisted Living bill of rights - Infection control techniques ULP-D ULP-D was hired on May 30, 2019, to provide direct care and services to the facility's residents. ULP-D's employee record lacked evidence the employee had successfully completed annual training as required, to include the following: - Assisted Living bill of rights - Infection control techniques On December 26, 2023, at 12:01 p.m., licensed assisted living director/registered nurse (LALD/RN)-A reviewed ULP-B, ULP-C and	{01500}			

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{01500}	Continued From page 25 ULP-D's employee records and stated they had not completed the above required training. The licensee's Employee Records policy, undated, indicated the employee record would include documentation of the required annual training and infection control. No further information was provided.	{01500}			
{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 about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the	{01640}			

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{01640}	Continued From page 26 licensee failed to ensure a written service plan was revised to reflect the current services provided for one of two residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1 was admitted on February 1, 2019, with diagnoses including seizure disorder, diabetes (disease that affects how the body uses blood sugar), and moderate mental retardation (cognitive deficits in functional and adaptive skills). R1's service plan dated November 1, 20223, indicated R1 received assistance with bathing, dressing, toileting, transfers, housekeeping, laundry, meals, and medication management. R1's physician orders dated October 10, 2023, indicated blood sugar check one time daily. R1's medication administration record (MAR) dated December 2023, indicated R1's blood sugar was checked once a day in the morning. On December 26, 2023, at 11:38 a.m. licensed assisted living director/registered nurse (LALD/RN)-A stated R1's service plan did not include blood sugar checks.	{01640}			

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{01640}	Continued From page 27 The licensee's Comprehensive Services policy, undated, indicated a RN would develop a personalized service plan to include all services received. No further information was provided.	{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 medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters.	{01650}			

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{01650}	Continued From page 28 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a service plan included the correct required content for two of two residents (R1, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 R1's diagnoses included seizure disorder, diabetes (disease that affects how the body uses blood sugar), and moderate mental retardation (cognitive deficits in functional and adaptive skills). R1's service plan dated November 1, 2023, indicated R1 received assistance with bathing, dressing, toileting, transfers, housekeeping, laundry, meals, and medication management. R1's service plan lacked: - 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	{01650}			

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{01650}	Continued From page 29 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 an 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. R3 R3's diagnoses included diabetes (disease that affects how the body uses blood sugar) and hypertension (high blood pressure). R3's service plan dated November 1, 2023, indicated R3 received assistance with bathing, grooming, dressing, housekeeping, laundry, meals, medication management and once daily blood sugar checks. R3's service plan lacked: - 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	{01650}			

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{01650}	Continued From page 30 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 an 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 December 26, 2023, at 11:19 a.m. licensed assisted living director/registered nurse (LALD/RN)-A stated he had updated the service plan document for all residents, but the service plans did not include the required content as listed above. No further information was provided.	{01650}			
{01710} SS=E	144G.71 Subd. 3 Individualized medication monitoring and reas The assisted living facility must monitor and reassess the resident's medication management services as needed under subdivision 2 when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted a face-to-face medication management reassessment to	{01710}			

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NAME OF PROVIDER OR SUPPLIER SERENDIPITOUS LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 7935 UPPER 139TH COURT WEST APPLE VALLEY, MN 55124		
(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	
{01710}	Continued From page 31 include all required content for two of two residents (R1, R3). 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's diagnoses included seizure disorder, diabetes (disease that affects how the body uses blood sugar), and moderate mental retardation (cognitive deficits in functional and adaptive skills). R1's service plan dated November 1, 2023, indicated R1 received assistance with medication management. R1's physician orders dated October 10, 2023, included: - clobazam 10 milligrams (mg); take 1.5 tablets (=15 mg) by mouth twice daily for seizure disorder - divalproex DR 250 mg; take 2 tablets (=500 mg) by mouth every morning for seizure disorder - divalproex DR 250 mg; take 3 tablets (=750 mg) by mouth at bedtime for seizure disorder - lamotrigine 150 mg; take 1 tablet by mouth twice daily for seizure disorder - levocarnitine 330 mg; take 2 tablets (=660 mg) by mouth three times daily for kidney disease - Metformin 500 mg; take 2 tablets by mouth	{01710}			

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{01710}	Continued From page 32 twice daily for diabetes - Calcium/Vit D 600-400 mg-unit; take 1 tablet twice daily for bone health - Vitamin D3 25 micrograms (mcg); take 3 tablets by mouth daily for bone health - Losartan 25 mg; take 1 tablet my mouth daily for blood pressure - docusate sodium 100 mg; take 1 capsule twice daily by mouth for constipation - melatonin 5 mg; take 2 tablets (=10 mg) at bedtime for insomnia (difficulty falling asleep) - atorvastatin calcium 10 mg; take 1 tablet daily for elevated cholesterol - Trulicity Inject 0.75 mg/0.5 milliliters (ml); Inject 0.75 mg one time a week for diabetes - blood sugar check every a.m. for diabetes Licensed assisted living director (LALD)/RN-A was unable to locate R1's medication management assessment. R1's record lacked evidence the RN conducted a review of all medications the residents were known to be taking including a review of the side effects and contraindications annually. R3 R3's diagnoses included diabetes (disease that affects how the body uses blood sugar) and hypertension (high blood pressure). R3's service plan dated November 1, 2023, indicated R3 received assistance with medication management. R3's physician orders dated November 7, 2023, included: - amlodipine 5 mg; take 1 tablet by mouth daily for hypertension - aspirin 81 mg; take 1 tablet by mouth daily for	{01710}			

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{01710}	Continued From page 33 maintenance - latanoprost 0.005% eye drop solution: place 1 drop into right eye daily for macular degeneration - loratadine 10 mg; take 1 tablet by mouth daily for allergies - losartan 100 mg; take 1 tablet by mouth daily for blood pressure - metformin 500 mg; take 2 tablets by mouth twice daily for diabetes - prednisolone acetate 1% eye drop solution, place 1 drop into right eye twice daily for macular degeneration - Simvastatin 20 mg; take 1 tablet by mouth at bedtime for cholesterol - ensure; 1 bottle by mouth twice daily for health maintenance - blood sugar checks twice daily for diabetes LALD/RN-A was unable to locate R3's medication management assessment. R3's record lacked evidence the RN conducted a review of all medications the residents were known to be taking including a review of the side effects and contraindications annually. On December 26, 2023, at 1:15 p.m. LALD/RN-A stated R1 and R3's medication management assessment had not been reassessed annually. The licensee's Individualized Medication Monitoring and Reassessment policy, undated, indicated the RN would monitor and reassess residents' medication services as needed (change in condition, adverse effects, hospitalization, etc.) or when the resident presents symptoms of or other issues that may be medication related. It further indicated medication reassessment would never exceed six months.	{01710}			

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{01710}	Continued From page 34	{01710}			
	No further information was provided.				
{01730} SS=E	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 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.	{01730}			

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{01730}	Continued From page 35 (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 interview, and record review, the licensee failed to develop an individualized medication management plan with the required content for two of two residents (R1, R3). 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's diagnoses included seizure disorder, diabetes (disease that affects how the body uses blood sugar), and moderate mental retardation (cognitive deficits in functional and adaptive skills). R1's service plan dated November 1, 2023, indicated R1 received assistance with medication management. R1's physician orders dated October 10, 2023,	{01730}			

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{01730}	Continued From page 36 included: - clobazam 10 milligrams (mg); take 1.5 tablets (=15 mg) by mouth twice daily for seizure disorder - divalproex DR 250 mg; take 2 tablets (=500 mg) by mouth every morning for seizure disorder - divalproex DR 250 mg; take 3 tablets (=750 mg) by mouth at bedtime for seizure disorder - lamotrigine 150 mg; take 1 tablet by mouth twice daily for seizure disorder - levocarnitine 330 mg; take 2 tablets (=660 mg) by mouth three times daily for kidney disease - Metformin 500 mg; take 2 tablets by mouth twice daily for diabetes - Calcium/Vit D 600-400 mg-unit; take 1 tablet twice daily for bone health - Vitamin D3 25 micrograms (mcg); take 3 tablets by mouth daily for bone health - Losartan 25 mg; take 1 tablet my mouth daily for blood pressure - docusate sodium 100 mg; take 1 capsule twice daily by mouth for constipation - melatonin 5 mg; take 2 tablets (=10 mg) at bedtime for insomnia (difficulty falling asleep) - atorvastatin calcium 10 mg; take 1 tablet daily for elevated cholesterol - Trulicity Inject 0.75 mg/0.5 milliliter (ml); Inject 0.75 mg one time a week for diabetes - blood sugar check every a.m. for diabetes R1's record lacked evidence of a medication management plan to include: - statement describing the medication management services that will be provided; - description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; - documentation of specific resident instructions relating to the administration of medications;	{01730}			

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{01730}	Continued From page 37 - identification of persons responsible for monitoring medication supplies and ensuring medication refills are ordered on a timely basis; - identification of medication management tasks that may be delegated to unlicensed personnel; - procedures for staff notifying a registered nurse (RN) when a problem arose with medication management services and; - any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication to use to prevent possible complications or adverse reactions. R3 R3's diagnoses included diabetes (disease that affects how the body uses blood sugar) and hypertension (high blood pressure). R3's service plan dated November 1, 2023, indicated R3 received assistance with medication management. R3's physician orders dated November 7, 2023, included: - amlodipine 5 mg; take 1 tablet by mouth daily for hypertension - aspirin 81 mg; take 1 tablet by mouth daily for maintenance - latanoprost 0.005% eye drop solution: place 1 drop into right eye daily for macular degeneration - loratadine 10 mg; take 1 tablet by mouth daily for allergies - losartan 100 mg; take 1 tablet by mouth daily for blood pressure - metformin 500 mg; take 2 tablets by mouth twice daily for diabetes - prednisolone acetate 1% eye drop solution, place 1 drop into right eye twice daily for macular	{01730}			

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{01730}	Continued From page 38 degeneration - Simvastatin 20 mg; take 1 tablet by mouth at bedtime for cholesterol - ensure; 1 bottle by mouth twice daily for health maintenance - blood sugar checks twice daily for diabetes On December 26, 2023, at 1:15p.m. licensed assisted living director/registered nurse (LALD/RN)-A stated R1 and R3's record lacked a medication management plan to include all the required content as noted above. The licensee's Individualized Medication Management Plan policy, undated, indicated a RN would prepare a written medication management plan specific to each resident receiving medication management services. The medication management plan would include the following: -statement of services being provided - description of storage of medications based on residents' preferences, risk of diversion and manufacturer's directions - specific instructions relating to the resident's administration of medications - identifying the person in charge of monitoring prescriptions and supplies ensuring they are refilled on a timely basis - identifying tasks that may be delegated to ULP - procedures for contacting the RN with questions or concerns - resident specific instructions regarding administration, verification of administration and monitoring of medication use to prevent complications or adverse effects - record would be current and updated when any changes occurred - reconciliation would be completed when RN is providing medication management	{01730}			

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{01730}	Continued From page 39	{01730}			
	No further information was provided.				
{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 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;	{01790}			

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{01790}	Continued From page 40 (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 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 training and competencies for three of three unlicensed personnel (ULP-B, ULP-C, ULP-D) providing medications to residents for unplanned time away from home when the licensed nurse was not available. 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	{01790}			

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{01790}	Continued From page 41 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: ULP-B ULP-B was hired on September 15, 2019. ULP-B's employee record lacked documentation of training and competencies for unplanned time away when the RN was not available. ULP-C ULP-C was hired on January 31, 2019. ULP-C's employee record lacked documentation of training and competencies for unplanned time away when the RN was not available. ULP-D was hired on May 30, 2019. ULP-D's employee record lacked documentation of training and competencies for unplanned time away when the RN was not available. On December 26, 2023, at 12:55 p.m. licensed assisted living director (LALD)/RN-A stated ULP-B, ULP-C and ULP-D were trained, and competency tested on providing medications to residents for unplanned time away, but their records lacked evidence of its completion. LALD/RN-A further stated all ULP records lacked evidence of this training and competency testing. The licensee's Staff Requirements policy, undated, indicated before performing delegated tasks, ULP would complete training of that task and demonstrate competency either with an oral or written exam and would perform a practical	{01790}			

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{01790}	Continued From page 42 skills test of the task with the RN. No further information provided.	{01790}			
{01880} SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were secure and permitted access to only authorized personnel. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On December 26, 2023, at 9:30 a.m. during the entrance conference, the surveyor observed an unlocked cabinet in the common area with medications stored in it. Licensed assisted living director/registered nurse stated the unlocked cabinet held the residents over the counter (OTC) and as needed (PRN) medications.	{01880}			

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{01880}	Continued From page 43 Over the course of the survey, the surveyor observed residents use the common office area with the unsecured cabinet with no staff present in the area. Residents would have access to the unsecured medications in the cabinet. The licensee's Storage of Medications policy, undated, indicated all medications would be stored in a locked container that is only accessible to staff with prior authorization. No further information provided.	{01880}			
{01940} SS=E	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; (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	{01940}			

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{01940}	Continued From page 44 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 and implement a treatment or therapy management plan to include all required content for two of two residents (R1, R3). 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's diagnoses included seizure disorder, diabetes (disease that affects how the body uses blood sugar), and moderate mental retardation (cognitive deficits in functional and adaptive skills). R1's service plan dated November 1, 2023, indicated R1 received assistance with bathing, grooming, dressing, toileting, transfers, housekeeping, laundry, meals, and medication management. The service plan lacked the	{01940}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37368	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 12/26/2023
NAME OF PROVIDER OR SUPPLIER SERENDIPITOUS LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 7935 UPPER 139TH COURT WEST APPLE VALLEY, MN 55124		
(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
{01940}	Continued From page 45 service of blood sugar checks. R1's signed physician orders dated October 10, 2023, indicated blood sugar check one time daily. R1's records lacked a treatment management plan to include the following required content for blood sugar checks: - statement of the type of service that will be provided; - 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 when a problem arose 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. R3 R3's diagnoses included diabetes (disease that affects how the body uses blood sugar), and hypertension (high blood pressure). R3's service plan dated November 1, 2023, indicated R3 received assistance with bathing, grooming, dressing, housekeeping, laundry, meals, medication management and once daily blood sugar checks. R3's signed physician orders dated November 7, 2023, indicated blood sugar check twice daily. R3's records lacked a treatment management	{01940}			

Minnesota Department of Health

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{01940}	Continued From page 46 plan to include the following required content for blood sugar checks: - statement of the type of service that will be provided; - 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 when a problem arose 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. On December 26, 2023, at 11:24 a.m. licensed assisted living director/registered nurse (LALD/RN)-A stated R1 and R3's records lacked a treatment management plan to include all the required content as noted above. The licensee's Individualized Treatment and Therapy Management policy, undated, indicated the RN would create a treatment and therapy management plan for residents receiving treatment services to include: - statement of services provided - document of instruction for the services provided - identifying which treatment and/or therapy will be delegated to unlicensed personnel - Procedure for notifying the RN when question or concerns arise from the service - any additional documentation that is required for the successful and safe application of that treatment or therapy	{01940}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37368	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 12/26/2023
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{01940}	Continued From page 47 - documentation of the administration of the treatment or therapy - monitoring the treatment or therapy for possible complications or adverse reactions No further information was provided.	{01940}			
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 interview, and record review, the licensee failed to transcribe a treatment order for one of one resident (R3). 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			

Minnesota Department of Health

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01960	Continued From page 48 R3's diagnoses included diabetes (disease that affects how the body uses blood sugar), and hypertension (high blood pressure). R3's service plan dated November 1, 2023, indicated R3 received assistance with daily blood sugar checks. R3's medication administration record (MAR) dated December 2023, indicated once daily blood sugar checks. R3's signed physician orders dated November 7, 2023, indicated blood sugar check twice daily. On December 26, 2023, at 11:38 a.m. licensed assisted living director/registered nurse (LALD/RN)-A stated it was R3's preference to have her blood sugar checked once a day instead of twice a day. LALD/RN-A further stated he had not received an updated order to check R3's blood sugar once a day. The licensee's Treatment and Therapy Management Services policy, undated, indicated the licensee would follow physician orders for all treatments provided. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

November 1, 2023

Licensee
Serendipitous Living
7935 Upper 139th Court West
Apple Valley, MN 55124

RE: Project Number(s) SL37368015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on October 4, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement.

Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;

Level 3: a fine of \$3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.

Level 4: a fine of \$5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5), the MDH may impose fine amounts of either \$1,000 or \$5,000 to licensees who are found to be responsible for maltreatment.

The MDH may impose a fine of \$1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The MDH also may impose a fine of \$5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

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

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

St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - \$3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$3,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

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

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

Please address your cover letter for reconsideration requests to:

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

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 MDH within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. 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 the letter and state form with your organization's Governing Body.

If you have any questions, please contact me.

Sincerely,



Jodi Johnson, Supervisor
State Evaluation Team
Email: jodi.johnson@state.mn.us
Telephone: 507-344-2730 Fax: 1-866-890-9290

JMD

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37368	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/04/2023
NAME OF PROVIDER OR SUPPLIER SERENDIPITOUS LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 7935 UPPER 139TH COURT WEST APPLE VALLEY, MN 55124			
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0 000	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: SL37368015-0 On October 2, 2023, through October 4, 2023, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were five active residents; five receiving services under the Assisted Living license. 2310: The immediacy was lifted on October 4, 2023, but non-compliance remains at a level 3/widespread (I).	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living 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.		
0 250 SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a	0 250			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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0 250	Continued From page 1 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, or interferes with or impedes access by the Office of Ombudsman for Mental Health and Developmental Disabilities according to section 245.94, subdivision 1; (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			

Minnesota Department of Health

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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 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. 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: During the entrance conference on October 2, 2023, at 10:24 a.m., licensed assisted living director/registered nurse (LALD/RN)-A stated the	0 250			

Minnesota Department of Health

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0 250	Continued From page 3 licensee's employees in charge of the facility were familiar with the assisted living regulations. 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. - 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	0 250			

Minnesota Department of Health

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0 250	Continued From page 4 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 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	0 250			

Minnesota Department of Health

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0 250	Continued From page 5 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 the licensee's agent on November 9, 2022. The licensee had an assisted living license issued on March 1, 2023, with an expiration date of February 29, 2024. The licensee failed to ensure the following policies and procedures were developed and/or implemented: (1) requirements in section 626.557, reporting of maltreatment of vulnerable adults; (2) orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; (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) orientation to and implementation of the assisted living bill of rights; (5) infection control practices; (6) 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	0 250			

Minnesota Department of Health

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0 250	Continued From page 6 and Prevention standards; and (7) medication and treatment management; As a result of this survey, the following orders were issued 0630, 0640, 0660, 1290, 1370, 1500, 1620, 1710, 1730, 1770, 1790, 1830, 1880, 1910, 1940, and 2310, 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			
0 430 SS=C	144G.40 Subd. 2 Uniform checklist disclosure of services (a) All assisted living facilities must provide to prospective residents: (1) a disclosure of the categories of assisted living licenses available and the category of license held by the facility; (2) a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and (3) an oral explanation of the services offered under the contract. (b) The requirements of paragraph (a) must be completed prior to the execution of the assisted living contract. (c) The commissioner must, in consultation with all interested stakeholders, design the uniform checklist disclosure form for use as provided	0 430			

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NAME OF PROVIDER OR SUPPLIER SERENDIPITOUS LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 7935 UPPER 139TH COURT WEST APPLE VALLEY, MN 55124		
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0 430	Continued From page 7 under paragraph (a). This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a copy of the uniform disclosure of assisted living and services (UDALSA) with the required content for one of one resident (R1). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 was admitted on February 1, 2019, and received services to include assistance with bathing, dressing, toileting, transfers, housekeeping, laundry, meals, and medication management. R1's record lacked documentation of receiving a UDALSA to include: - a disclosure of the categories of assisted living licenses available and the category of license held by the facility - a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and - an oral explanation of all services offered under the contract.	0 430			

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0 430	Continued From page 8 On October 3, 2023, at 10:32 a.m., licensed assisted living director/registered nurse (LALD/RN)-A stated he had not provided any of the current residents a copy of the UDALSA. No further information was provided. PERIOD OF CORRECTION: Twenty-one (21) days	0 430			
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	0 470			

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0 470	Continued From page 9 appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on 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; and failed to ensure the staffing schedule was posted as required. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee held and assisted living license. The facility was licensed for a capacity of five and had a current census of five residents. During the entrance conference on October 2, 2023, at 10:24 a.m., licensed assisted living director/registered nurse (LALD/RN)-A stated the licensee had not developed a staffing plan or posted a staff schedule. No further information was provided. TIME PERIOD OF CORRECTION: Seven (7) days	0 470			

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0 480	Continued From page 10	0 480			
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: (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 October 3, 2023, for the specific Minnesota Food code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	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	0 580			

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0 580	Continued From page 11 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 implement and maintain a quality management program (QMP) appropriate to the size of the facility and relevant to the type of services provided. This had the potential to affect all current 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 the residents). The findings include: On October 2, 2023, at 10:24 a.m. during the entrance conference, licensed assisted living director/registered nurse (LALD/RN)-A stated the licensee had not created or implemented a QMP. LALD/RN-A stated he was not aware of the requirement to create and maintain a QMP.	0 580			

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0 580	Continued From page 12 The licensee's quality management program policy, undated, indicated the licensee would establish a quality improvement program on the organization's size and appropriate to the type of services provided to assure that effective, comprehensive, and appropriate plans are operational for all clients with the organization would engage in quality management plan relevant to the type of services the licensee provided. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 580			
0 630 SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for one of one resident (R1).	0 630			

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0 630	Continued From page 13 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1's diagnoses included seizure disorder, diabetes (disease that affects how the body uses blood sugar), and moderate mental retardation (cognitive deficits in functional and adaptive skills). R1's service plan dated December 9, 2022, indicated R1 received assistance with bathing, dressing, toileting, transfers, housekeeping, laundry, meals, and medication management. On October 2, 2023, at 1:38 p.m., the surveyor observed unlicensed personnel (ULP)-B administer R1's medications. R1's IAPP dated December 9, 2022, identified the following areas of vulnerability: - Resident is at risk to be abused by others, specify measures to minimize risk: this section was left blank. - orientation x 3, specify measures to minimize risk: this section was left blank. - adequate speech, specify measures to minimize risk: this section was left blank. - adequate communication, specify measures to minimize risk: this section was left blank. - cooperative behavior, specify measures to minimize risk: this section was left blank.	0 630		

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0 630	Continued From page 14 - ability to adhere to safety precautions consistently, specify measures to minimize risk: this section was left blank. - ability to report abuse and/or neglect, specify measures to minimize risk: this section was left blank. - ability to use the telephone, specify measures to minimize risk: this section was left blank. R1's IAPP did not include specific interventions for the identified vulnerabilities as required. On October 3, 2023, at 9:41 a.m., licensed assisted living director/registered nurse (LALD/RN)-A reviewed R1's IAPP and stated R1's IAPP was missing interventions for identified vulnerabilities. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language.	0 640		

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0 640	Continued From page 15 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to support protection and safety by not posting information and phone numbers for reporting to the Minnesota Adult Abuse Reporting Center (MAARC) as required. 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: The licensee failed to post information and the reporting number for MAARC to report suspected maltreatment of a vulnerable adult under section 626.557. On October 2, 2023, at 11:00 a.m., the surveyor observed the entry and common areas within the facility and noted there was no posting of the information and reporting number for MAARC, as required. Licensed assisted living director/registered nurse (LALD/RN)-A stated the MAARC information was not posted. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 640			

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0 650	Continued From page 16	0 650			
0 650 SS=F	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. 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 two of two employees (unlicensed personnel (ULP)-B and ULP-C). 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	0 650			

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0 650	Continued From page 17 cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-B ULP-B was hired September 15, 2019, to provide direct care and services to the facility's residents. On October 2, 2023, at 1:38 p.m., ULP-B was observed to administer medication to R1. ULP-B's record lacked the following: - resident specific competency evaluations; - documentation of annual performance reviews that identify areas of improvement needed and training needs ULP-B's Required Caregiver Orientation Checklist form signed by a registered nurse (RN) on October 3, 2019, did not include training/competency for administration of oral medications, blood sugar checks or insulin administration. ULP-C ULP-C was hired on January 31, 2019, to provide direct care and services to the facility's residents. On October 3, 2023, at 2:30 p.m., ULP-C was observed assisting R4 with a transfer from bed to wheelchair. ULP-C's record lacked the following: - resident specific competency evaluations; - current job description, including qualifications, responsibilities, and identification of staff persons	0 650		

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0 650	Continued From page 18 providing supervision; - documentation of annual performance reviews that identify areas of improvement needed and training needs ULP-C's Required Caregiver Orientation Checklist form signed by an RN on January 20, 2023, did not include training/competency for administration of oral medications, blood sugar checks or insulin administration. On October 4, 2023, at 9:35 a.m., licensed assisted living director(LALD)/RN-A stated ULP-B and ULP-C were trained and competent to administer all medication routes, but their record lacked evidence of training/competency as he kept competency evaluations for all ULP in the resident records and not in the employee files. LALD/RN-A further stated ULP-B's record lacked an annual performance review and ULP-C's record lacked a job description and annual performance review. The licensee's Delegation of Assisted Living Services policy, undated, indicated no ULP shall perform a delegated task unless a staff RN has deemed them to be competent and has watched the ULP demonstrate their competency. This competency must be documented in the employee file. 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	0 660			

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0 660	Continued From page 19 (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 program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included documentation of a completed health history and symptom screening for two of two employees (unlicensed personnel (ULP)-B, ULP-C). In addition, the licensee failed to complete a facility tuberculosis (TB) risk assessment. This had the potential to affect all residents, staff and visitors of the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect	0 660			

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0 660	Continued From page 20 a large portion or all of the residents). The findings include: On, October 2, 2023, at 1:45 p.m., licensed assisted living director/registered nurse (LALD/RN)-A provided a facility TB risk assessment dated September 15, 2022, but it was for a different facility. ULP-B ULP-B was hired September 15, 2019, to provide direct care and services to the facility's residents. On October 2, 2023, at 1:38 p.m., ULP-B was observed to administer medication to R1. ULP-B's employee record contained a negative one step tuberculin skin test (TST) dated July 18, 2019; however, ULP-B's employee record lacked evidence of the following: - second step TST - TB history and symptom screening ULP-C ULP-C was hired on January 31, 2019, to provide direct care and services to the facility's residents. On October 3, 2023, at 2:30 p.m. ULP-C was observed assisting R4 with a transfer from bed to wheelchair. ULP-C's employee record contained a negative one step TST dated February 4, 2023; however, ULP-C's employee record lacked evidence of the following: - second step TST - TB history and symptom screening On October 4, 2023, at 9:35 a.m. LALD/RN-A	0 660		

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NAME OF PROVIDER OR SUPPLIER SERENDIPITOUS LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 7935 UPPER 139TH COURT WEST APPLE VALLEY, MN 55124		
(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
0 660	Continued From page 21 stated ULP-B and ULP-C's employee files were missing the above listed content. LALD/RN-A further stated the current facility TB risk assessment was for a different facility and thought he had updated it. The licensee's Tuberculosis Prevention and Screening Plan policy, undated, indicated staff would be assessed for current symptoms of active TB disease and would be tested for the presence of infection with Mycobacterium tuberculosis by administering either a two-step TST or single TB blood test. It further indicated the licensee would complete a risk assessment every two years or sooner when appropriate. 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 elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents.	0 680			

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0 680	Continued From page 22 (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 post an emergency disaster plan prominently, have a written emergency preparedness (EP) plan with all the required content. This had the potential to affect all residents, staff, and visitors of the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: EMERGENCY PLAN POSTED On October 2, 2023, at 11:00 a.m., during the facility tour with licensed assisted living director/registered nurse (LALD/RN)-A, the surveyor did not observe any signage or information regarding the licensee's emergency disaster or preparedness plan posted. At this time, LALD/RN-A stated the plan was not posted	0 680			

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0 680	Continued From page 23 prominently and was not aware of the requirement. EMERGENCY PREPAREDNESS PLAN (EPP) CONTENT The licensee's Emergency Preparedness plan, undated, was reviewed and lacked the following: - establish and maintain a comprehensive EPP, reviewed/updated annually; - how they would coordinate with other health care facilities and community during an emergency or disaster (natural, man-made, facility, etc.), reviewed/updated annually; - documented date of reviews and updates; - community risk assessment with documentation; - consider duration of interruptions; - arrangements/contracts to re-establish utility services; - develop strategies for addressing community-based risks (evacuation plans, staffing/shortage, back-up plans); - an assessment of at-risk population's needs including maintaining independence, communication, transportation, supervision, and medical care; - must identify which staff would assume specific roles in another's absence through succession planning and delegation of authority; - a qualified person who is authorized, in writing, to act in the absence of the administrator; - a process for cooperation and collaboration with local, tribal, regional, State and Federal EP to maintain integrated response; - develop and implement EP policies/procedures and review/update annually; - develop/implement EP policies and procedures to address evacuation and shelter in place for staff and residents which must include: - alternate sources of energy to maintain	0 680			

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0 680	Continued From page 24 temperature, safety and sanitary storage of provisions; - alternate sources of energy to fire detection, extinguishing, alarms systems; - a tracking system used to document locations of residents, staff, and relocation of staff; - develop policies and procedures to address safe evacuation from the facility including: - needs of evacuees; - staff responsibilities; - transportation; - alternate communication means; - develop policy and procedures for shelter in place for residents, staff and volunteers who remain at the facility; - develop policy and procedures to address: - systems of medical documentation that preserve resident information; - protects confidentiality; - secures/maintains availability of records; - develop policy and procedures must address use of volunteers including process and role for integration; - develop policy and procedures which address development and arrangements with other facilities or providers to receive residents in the event continuity of services cannot be provided; - develop a written communication plan and review/update annually; - communication plan must include all the following names/contact information: - entities providing services under agreement; - residents' physicians; - volunteers; - communication plan must include contact information for: - other sources of assistance; - communication plan must include:	0 680			

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0 680	Continued From page 25 - means to provide information about facility occupancy; - and ability to provide assistance; - authority having jurisdiction; - incident Command Center; - or designee; - communication plan must include a method for sharing information from emergency plan; - must develop and maintain EP training and testing program, review/update annually; - must conduct exercises to test the EP plan at least twice per year including unannounced staff drills using the EP; - must implement emergency and standby power systems based on their EP; and - if part of a healthcare system consisting of separately certified healthcare facilities and elects to have a unified and integrated EP, they may choose to participate. On October 4, 2023, at 10:00 a.m., LALD/RN-A stated the licensee's current EP plan did not include the above content. LALD/RN-A further stated he was not aware of all the required content. The licensee's Emergency Preparedness policy, undated, indicated the licensee would have an identified plan in place to assure the safety and well-being of clients and staff during periods of an emergency disaster that disrupts services. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			
0 690 SS=D	144G.43 Subdivision 1 Resident record	0 690			

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0 690	Continued From page 26 (a) Assisted living facilities must maintain records for each resident for whom it is providing services. Entries in the resident records must be current, legible, permanently recorded, dated, and authenticated with the name and title of the person making the entry. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure entries in one of one resident record (R1) were authenticated by the name and title of the person making the entry. 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's Medication Administration Record (MAR) dated October 2023, was reviewed and had a page for staff to write in their name, title, and initials. Unlicensed personnel (ULP)-B had initials on R1's MAR dated October 2, 3, 2023; however, ULP-B was not identified by title on R1's October MAR. On October 3, 2023, at 9:11 a.m. licensed assisted living director/registered nurse (LALD/RN)-A stated each employee should have their name with title and initials on each resident's MAR.	0 690			

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0 690	Continued From page 27 The licensee's Resident Records policy, undated, indicated all entries into the clinical record would be legible, permanently recorded in ink, dated, and authenticated with the name and title of the person making the entry. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 690			
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 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	0 730			

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0 730	Continued From page 28 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 the required documentation of all provided services for one of one resident (R1). The licensee further failed to ensure the resident record included a discharge summary with the required content for one of one discharged resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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).	0 730			

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0 730	Continued From page 29 The findings include: R1's start of care was February 1, 2019, with diagnoses including seizure disorder, diabetes (disease that affects how the body uses blood sugar), and moderate mental retardation (cognitive deficits in functional and adaptive skills). R1's service plan dated December 9, 2022, indicated R1 received assistance with bathing, dressing, toileting, transfers, housekeeping, laundry, meals, and medication management. R1's record lacked documentation that services were provided as scheduled. DISCHARGE SUMMARY R2 was admitted to the licensee on June 19, 2019, with diagnosis of seizure disorder and depression. R2 discharged from the facility on October 8, 2021. R2's record lacked a discharge summary to include: - course of illness; - allergies; - treatments and therapies; - pertinent lab, radiology, and consultation results; and - a final summary of the resident's status from the latest assessment or review including baseline and current mental, behavioral, and functional status. On October 4, 2023, at 9:35 a.m., licensed assisted living director/registered nurse (LALD/RN)-A stated staff did not document assistance with activities of daily living for any of	0 730			

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0 730	Continued From page 30 the residents receiving these services. LALD/RN-A further stated R2's discharge summary did not include all the required content. The licensee's Resident Record policy, undated, indicated the resident record would contain documentation of services provided as identified in the service plan. It further indicated the record would contain a discharge summary when applicable. No further information was provided. TIME PERIOD FOR CORRECTIONS: Twenty-one (21) days	0 730		
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	0 780		

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0 780	Continued From page 31 (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed smoke alarms that were interconnected so that the actuation of one alarm causes all alarms to operate. This deficient condition had the ability to affect all staff and 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 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: On a facility tour on October 2, 2023, at approximately 11:20 a.m., with Licensed Assisted Living Director/ Registered Nurse (LALD/ RN)-A it was observed that the smoke alarms were not interconnected so that the operation of one alarm caused all alarms to operate when tested by the facility staff. LALD/ RN-A visually verified this deficient condition at the time of discovery. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780		

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0 790	Continued From page 32	0 790			
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 and interview, the licensee failed maintain portable fire extinguishers as required for the facility. This deficient condition had the ability to affect all staff and 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 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: On a facility tour on October 2, 2023, at approximately 12:00 p.m., with Licensed Assisted Living Director/ Registered Nurse (LALD/ RN)-A it was observed that the fire extinguishers	0 790			

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0 790	Continued From page 33 maintenance tag monthly inspections were not completed as required by Minnesota State Fire Code. LALD/ RN-A visually verified this deficient condition at the time of discovery. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 790		
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	0 810		

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0 810	Continued From page 34 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 a record review and interview, the licensee failed to provide a fire safety and evacuation plan with the required elements, failed to provide required employee and resident training on the fire safety and evacuation plan, and failed to conduct required evacuation drills. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: A record review and interview were conducted on October 3, 2023, at approximately 1:40 p.m., with Licensed Assisted Living Director/ Registered Nurse (LALD/ RN)-A on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. Record review indicated that the licensee had an EP plan, but this did not address fire safety and evacuation and did not have a separate fire safety and evacuation plan.	0 810			

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NAME OF PROVIDER OR SUPPLIER SERENDIPITOUS LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 7935 UPPER 139TH COURT WEST APPLE VALLEY, MN 55124		
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0 810	Continued From page 35 Record review indicated that the fire safety and evacuation plan did not have employee actions to be taken in the event of a fire or similar emergency. Record review indicated that the fire safety and evacuation plan did not have fire protection procedures necessary for residents. Record review indicated that the fire safety and evacuation plan did not include the identification of unique or unusual resident needs for movement or evacuation in the procedures for resident movement, evacuation, or relocation during a fire or similar emergency. Record review indicated that employees did not receive training twice per year after initial hire on the facility fire safety and evacuation plan. Record review indicated that the licensee did not provide training to residents who are capable of self-evacuation on the proper actions to be taken in the event of a fire in regard to movement, evacuation, and relocation. Record review indicated that that the licensee did not have documentation indicating that evacuation drills had been conducted every other month as required. During interview, LALD/ RN-A verified these deficient conditions. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810			

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01290	Continued From page 36	01290		
01290 SS=F	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 by: Based on interview and record review, the licensee failed to ensure a background study was affiliated with the assisted living facility (ALF) license for two of two employees (unlicensed personnel (ULP)-B, ULP-C). This had the potential to affect all residents living in the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include:	01290		

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01290	Continued From page 37 ULP-B ULP-B was hired on September 15, 2019, to provide direct care and services to the facility's residents. ULP-B's employee record contained a Background Study Clearance dated September 6, 2019, from a sister facility. However, the document was not affiliated with the facility's license. ULP-C ULP-C was hired on January 31, 2019, to provide direct care and services to the facility's residents. ULP-C's employee record contained a Background Study Clearance dated March 18, 2020, from a sister facility. However, the document was not affiliated with the facility's license. On October 4, 2023, at 9:35 a.m., licensed assisted living director/registered nurse (LALD/RN)-A stated ULP-B and ULP-C had worked at a sister facility and therefore did not believe ULP-B and ULP-C were required to have a background study affiliated with the current ALF. The licensee's Employee Record policy, undated, indicated each employee record would have documentation of a background study and fingerprints as required. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290			

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01370	Continued From page 38	01370			
01370 SS=F	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 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	01370			

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01370	Continued From page 39 (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 and competency was completed for two of two employees (unlicensed personnel (ULP)-B and ULP-C) to include all required content. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-B ULP-B was hired on September 15, 2019, to provide direct care and services to the facility's residents. On October 3, 2023, at 7:23 a.m., the surveyor observed ULP-B check R1's temperature, blood pressure and oxygen saturation and administer R1's morning medications. ULP-B's employee record lacked evidence of competency evaluations for the following topics: - appropriate and safe techniques in personal hygiene and grooming, including: - hair care and bathing - care of teeth, gums and oral prosthetic devices	01370			

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01370	Continued From page 40 - care and use of hearing aids - dressing and assisting with toileting - standby assistance techniques and how to perform them - reading and recording temperature, pulse, and respirations of the client - safe transfer techniques and ambulation - range of motion and positioning - administering medications or treatments as required ULP-C ULP-C was hired on January 31, 2019, to provide direct care and services to the facility's residents. On October 3, 2023, at 2:30 p.m., ULP-C was observed assisting R4 with a transfer from bed to wheelchair. ULP-C's employee record lacked evidence of competency evaluations for the following topics: - appropriate and safe techniques in personal hygiene and grooming, including: - hair care and bathing - care of teeth, gums and oral prosthetic devices - care and use of hearing aids - dressing and assisting with toileting - standby assistance techniques and how to perform them - reading and recording temperature, pulse, and respirations of the client - safe transfer techniques and ambulation - range of motion and positioning - administering medications or treatments as required On October 4, 2023, at 9:35 a.m., licensed assisted living director/registered nurse (LALD/RN)-A stated ULP-B and ULP-C were	01370			

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01370	Continued From page 41 trained and competent in all the areas listed above, but their record lacked evidence of competencies. The licensee's Staff Orientation and Education policy, undated, indicated all employees would attend and complete general orientation and those providing direct services would complete a competency evaluation as part of the orientation process. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370			
01500 SS=E	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and	01500			

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01500	Continued From page 42 reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the 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 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 annual training included all required topics for each 12 months of	01500			

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01500	Continued From page 43 employment for two of two employees (unlicensed personnel (ULP)-B and ULP-C). 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: ULP-B ULP-B was hired on September 15, 2019, to provide direct care and services to the facility's residents. ULP-B's employee record lacked evidence the employee had successfully completed annual training as required, to include the following: - Reporting maltreatment of vulnerable adults or minors - Assisted Living bill of rights - Review of provider's policies and procedures - Principles of person-centered planning/service delivery ULP-C ULP-C was hired on January 31, 2019, to provide direct care and services to the facility's residents. ULP-C's employee record lacked evidence the employee had successfully completed annual training as required, to include the following: - Reporting maltreatment of vulnerable adults or minors	01500			

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01500	Continued From page 44 - Assisted Living bill of rights - Infection control techniques - Review of provider's policies and procedures - Principles of person-centered planning/service delivery On October 4, 2023, at 9:35 a.m., licensed assisted living director/registered nurse (LALD/RN)-A reviewed ULP-B and ULP-C's employee records and stated they did not contain the above required annual training. The licensee's Employee Records policy, undated, indicated the employee record would include documentation of the required annual training and infection control. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500			
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must	01620			

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01620	Continued From page 45 be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) had completed and/or documented a comprehensive assessment to include required areas of assessment per Assisted Living Facilities: Minnesota Rules Chapter 4659, for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1's diagnoses included seizure disorder, diabetes (disease that affects how the body uses blood sugar), and moderate mental retardation (cognitive deficits in functional and adaptive skills). R1's service plan dated December 9, 2022,	01620		

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01620	Continued From page 46 indicated R1 received assistance with bathing, dressing, toileting, transfers, housekeeping, laundry, meals, and medication management. R1's last three assessments were requested. R1's Care Plan Review Assessments dated March 14, 2023, June 12, 2023, and September 9, 2023, were provided, and reviewed by the surveyor on October 3, 2023. The assessments did not include per Assisted Living Facilities: Minnesota Rules Chapter 4659.0150 Uniform Assessment Tool, the components required in subpart 2, section A, 1-3. On October 3, 2023, at 9:23 a.m., licensed assisted living director (LALD)/RN-A stated the resident's care plan was reviewed every 90 days and he would complete a full comprehensive assessment if a change of condition occurred. LALD/RN-A reviewed the criteria for the Uniform Assessment Tool and stated their 14-day, 90-day and change of condition assessments did not contain the required content for any of the residents. The licensee's Comprehensive Assessment policy, undated, indicated the RN would conduct a comprehensive assessment upon admission and reviewed and revised every 90 days and the assessment would include the following: - Client evaluation - Vulnerability assessment - Medication profile - Home health aide care plan - Emergency information - Fall risk assessment - Mental status assessment - Home safety checklist - Medication management plan	01620			

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01620	Continued From page 47 The Assisted Living Facilities: Minnesota Rules Chapter 4659.0150 Uniform Assessment Tool indicated: - Subpart 1. Definition. For purposed of this part, "Uniform Assessment Tool" means an assessment tool that meets the requirements of this part and is used by a licensee to comprehensively evaluate a resident's or prospective resident's physical, mental, and cognitive needs - Subp. 2. Assessment tool elements. Each facility must develop a uniform assessment tool. The facility may use any acceptable form or format for the tool, such as an online or a hard-copy paper assessment tool, as long as the tool includes the elements identified in this subpart. A uniform assessment tool must address the following: A. the resident's personal lifestyle preferences, including: (1) sleep schedule, dietary and social needs, leisure activities, and any other customary routine that is important to the resident's quality of life; (2) spiritual and cultural preferences; and (3) advance health care directives and end-of-life preferences, including whether a person has or wants to seek a "do not resuscitate" order and "do not attempt resuscitation order or "physician/provider orders for life-sustaining treatment: order. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to	01640		

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01640	Continued From page 48 (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 and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a written service plan was revised to reflect the current services provided for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally).	01640		

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01640	Continued From page 49 The findings include: R1 was admitted on February 1, 2019, with diagnoses including seizure disorder, diabetes (disease that affects how the body uses blood sugar), and moderate mental retardation (cognitive deficits in functional and adaptive skills). R1's service plan dated December 9, 2022, indicated R1 received assistance with bathing, dressing, toileting, transfers, housekeeping, laundry, meals, and medication management. R1's physician orders dated June 9, 2023, indicated blood sugar check one time daily. R1's medication administration record (MAR) dated October 2023, indicated R1's blood sugar was checked once a day in the morning. On October 3, 2023, at 7:18 a.m., the surveyor observed unlicensed personnel (ULP)-B check R1's blood sugar. On October 3, 2023, at 9:41 a.m., licensed assisted living director/registered nurse (LALD/RN)-A reviewed R1's service plan and stated it did not include blood sugar checks. The licensee's Comprehensive Services policy, undated, indicated a RN would develop a personalized service plan to include all services received. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640			

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NAME OF PROVIDER OR SUPPLIER SERENDIPITOUS LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 7935 UPPER 139TH COURT WEST APPLE VALLEY, MN 55124			
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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 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 interview and record review, the licensee failed to ensure a service plan included the correct required content for one of one resident (R1). This practice resulted in a level two violation (a	01650			

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01650	Continued From page 51 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1's diagnoses included seizure disorder, diabetes (disease that affects how the body uses blood sugar), and moderate mental retardation (cognitive deficits in functional and adaptive skills). R1's service plan dated December 9, 2022, indicated R1 received assistance with bathing, dressing, toileting, transfers, housekeeping, laundry, meals, and medication management. R1's service plan lacked: - 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	01650			

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01650	Continued From page 52 change in the resident's condition, including identification of an 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 October 3, 2023, at 9:41 a.m., licensed assisted living director/registered nurse (LALD/RN)-A stated R1's service plan was missing the required content as listed above. LALD/RN-A further stated this form of the service plan was used for all residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	01650			
01710 SS=F	144G.71 Subd. 3 Individualized medication monitoring and reassessment The assisted living facility must monitor and reassess the resident's medication management services as needed under subdivision 2 when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted a face-to-face medication management reassessment to include all required content for one of one resident (R1).	01710			

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01710	Continued From page 53 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on October 2, 2023, at 10:24 a.m., licensed assisted living director (LALD)/RN-A stated the licensee provided medication management services to the residents at the facility. R1's diagnoses included seizure disorder, diabetes (disease that affects how the body uses blood sugar), and moderate mental retardation (cognitive deficits in functional and adaptive skills). R1's service plan dated December 9, 2022, indicated R1 received assistance with medication management. R1's medication administration record dated October 2023, included three oral anti-convulsant medications, two anti-diabetic medication, one anti-hypertensive medication, one stool softener, two vitamin supplements, one medication to lower cholesterol and one medication to help with sleep. R1's physician orders included: - clobazam 10 milligrams (mg); take 1.5 tablets (=15 mg) by mouth twice daily for seizure	01710			

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01710	Continued From page 54 disorder; per physician order dated April 4, 2023. - divalproex DR 250 mg; take 2 tablets (=500 mg) by mouth daily for seizure disorder; per physician order dated March 27, 2022. - lamotrigine 150 mg; take 1 tablet by mouth daily for seizure disorder; per physician order dated April 11, 2023. - levocarnitine 330 mg; take 2 tablets by mouth three times daily for kidney disease; per physician order dated April 11, 2023. - Metformin 500 mg; take 2 tablets by mouth daily for diabetes; per physician order dated July 28, 2023. - Calcium/Vit D 600-400 mg-unit; take 1 tablet twice daily for bone health; per physician order dated November 25, 2022. - Vitamin D3 25 micrograms (mcg); take 3 tablets by mouth daily for bone health; per undated physician order. - Losartan 25 mg; take 1 tablet my mouth daily for blood pressure; per physician order dated July 28, 2023. - docusate sodium 100 mg; take 1 capsule twice daily by mouth for constipation; per physician order dated April 11, 2023. - melatonin 5 mg; take one tablet for insomnia (difficulty falling asleep); per physician order dated May 22, 2023. - atorvastatin calcium 10 mg; take 1 tablet daily for elevated cholesterol; per physician order dated August 24, 2023. - Trulicity Inject 0.75 mg/0.5 ml; Inject 0.75 mg one time a week for diabetes; per physician order dated June 28, 2023. - blood sugar check every am for diabetes; per physician order dated June 9, 2023. On October 3, 2023, at 7:23 a.m., unlicensed personnel (ULP)-B was observed to administer oral medications to administer R1.	01710			

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01710	Continued From page 55 LALD/RN-A was unable to locate R1's medication management assessment. R1's record lacked evidence the RN conducted a review of all medications the residents were known to be taking include a review of the side effects and contraindications annually. On October 4, 2023, at 9:35 a.m., LALD/RN-A stated R1's medications had not been reassessed by the RN annually and further stated was unaware of the requirement. The licensee's Individualized Medication Monitoring and Reassessment policy, undated, indicated the RN would monitor and reassess residents' medication services as needed (change in condition, adverse effects, hospitalization, etc.) or when the resident presents symptoms of or other issues that may be medication related. It further indicated medication reassessment would never exceed six months. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01710			
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	01730			

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01730	Continued From page 56 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 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 an individualized medication management plan with	01730			

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01730	Continued From page 57 the required content for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on October 2, 2023, at 10:24 a.m., licensed assisted living director/registered nurse (LALD/RN)-A stated the licensee provided medication management services to their residents. R1's diagnoses included seizure disorder, diabetes (disease that affects how the body uses blood sugar), and moderate mental retardation (cognitive deficits in functional and adaptive skills). R1's service plan dated December 9, 2022, indicated R1 received assistance with medication management. R1's physician orders included: - clobazam 10 milligrams (mg); take 1.5 tablets (=15 mg) by mouth twice daily for seizure disorder; per physician order dated April 4, 2023. - divalproex DR 250 mg; take 2 tablets (=500 mg) by mouth daily for seizure disorder; per physician order dated March 27, 2022. - lamotrigine 150 mg; take 1 tablet by mouth daily for seizure disorder; per physician order dated April 11, 2023.	01730			

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01730	Continued From page 58 - levocarnitine 330 mg; take 2 tablets by mouth three times daily for kidney disease; per physician order dated April 11, 2023. - Metformin 500 mg; take 2 tablets by mouth daily for diabetes; per physician order dated July 28, 2023. - Calcium/Vit D 600-400 mg-unit; take 1 tablet twice daily for bone health; per physician order dated November 25, 2022. - Vitamin D3 25 micrograms (mcg); take 3 tablets by mouth daily for bone health; per undated physician order. - Losartan 25 mg; take 1 tablet my mouth daily for blood pressure; per physician order dated July 28, 2023. - docusate sodium 100 mg; take 1 capsule twice daily by mouth for constipation; per physician order dated April 11, 2023. - melatonin 5 mg; take one tablet for insomnia (difficulty falling asleep); per physician order dated May 22, 2023. - atorvastatin calcium 10 mg; take 1 tablet daily for elevated cholesterol; per physician order dated August 24, 2023. - Trulicity Inject 0.75 mg/0.5 ml; Inject 0.75 mg one time a week for diabetes; per physician order dated June 28, 2023. - blood sugar check every am for diabetes; per physician order dated June 9, 2023. On October 3, 2023, at 7:23 a.m., the surveyor observed unlicensed personnel (ULP)-B administer R1's medication. R1's record lacked evidence of a medication management plan to include: - statement describing the medication management services that will be provided; - description of storage of medications based on the resident's needs and preferences, risk of	01730			

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01730	Continued From page 59 diversion, and consistent with the manufacturer's directions; - documentation of specific resident instructions relating to the administration of medications; - identification of persons responsible for monitoring medication supplies and ensuring medication refills are ordered on a timely basis; - identification of medication management tasks that may be delegated to unlicensed personnel; - procedures for staff notifying a registered nurse (RN) when a problem arose with medication management services and; - any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication to use to prevent possible complications or adverse reactions. On October 4, 2023, at 9:35 a.m., LALD/RN-A stated R1's record lacked a medication management plan to include all the required content as noted above. The licensee's Individualized Medication Management Plan policy, undated, indicated a RN would prepare a written medication management plan specific to each resident receiving medication management services. The medication management plan would include the following: -statement of services being provided - description of storage of medications based on residents' preferences, risk of diversion and manufacturer's directions - specific instructions relating to the resident's administration of medications - identifying the person in charge of monitoring prescriptions and supplies ensuring they are refilled on a timely basis	01730			

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01730	Continued From page 60 - identifying tasks that may be delegated to ULP - procedures for contacting the RN with questions or concerns - resident specific instructions regarding administration, verification of administration and monitoring of medication use to prevent complications or adverse effects - record would be current and updated when any changes occurred - reconciliation would be completed when RN is providing medication management 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 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 (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a	01770			

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01770	Continued From page 61 limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's record lacked documentation by the licensed nurse at the time of setup to include the name of medication, quantity of dose, times to be administered, and route of administration. During the entrance conference on October 2, 2023, at 10:24 a.m., licensed assisted living director/registered nurse (LALD/RN)-A stated the licensee provided medication management services to their residents, including medication set up. R1's diagnoses included seizure disorder, diabetes (disease that affects how the body uses blood sugar), and moderate mental retardation (cognitive deficits in functional and adaptive skills). R1's service plan dated December 9, 2022, indicated R1 received medication administration. R1's service plan did not include medication set up. R1's physician orders included: - clobazam 10 milligrams (mg); take 1.5 tablets (=15 mg) by mouth twice daily for seizure disorder; per physician order dated April 4, 2023. - divalproex DR 250 mg; take 2 tablets (=500 mg) by mouth daily for seizure disorder; per physician order dated March 27, 2022. - lamotrigine 150 mg; take 1 tablet by mouth daily for seizure disorder; per physician order dated April 11, 2023.	01770			

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01770	Continued From page 62 - levocarnitine 330 mg; take 2 tablets by mouth three times daily for kidney disease; per physician order dated April 11, 2023. - Metformin 500 mg; take 2 tablets by mouth daily for diabetes; per physician order dated July 28, 2023. - Calcium/Vit D 600-400 mg-unit; take 1 tablet twice daily for bone health; per physician order dated November 25, 2022. - Vitamin D3 25 micrograms (mcg); take 3 tablets by mouth daily for bone health; per undated physician order. - Losartan 25 mg; take 1 tablet my mouth daily for blood pressure; per physician order dated July 28, 2023. - docusate sodium 100 mg; take 1 capsule twice daily by mouth for constipation; per physician order dated April 11, 2023. - melatonin 5 mg; take one tablet for insomnia (difficulty falling asleep); per physician order dated May 22, 2023. - atorvastatin calcium 10 mg; take 1 tablet daily for elevated cholesterol; per physician order dated August 24, 2023. - Trulicity Inject 0.75 mg/0.5 ml; Inject 0.75 mg one time a week for diabetes; per physician order dated June 28, 2023. - blood sugar check every am for diabetes; per physician order dated June 9, 2023. On October 3, 2023, at 7:23 a.m., the surveyor observed unlicensed personnel (ULP)-B administer R1's medication from the pre-filled weekly medication box. On October 3, 2023, at 9:23 a.m., LALD/RN-A stated he completed a medication set-up for R1 every week. LALD/RN-A stated he followed R1's physician orders for the medication set-up and documented that a medication set-up had been	01770		

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01770	Continued From page 63 completed. LALD/RN-A stated he did not document the name of the medication, quantity of dose, times to be administered, or route of administration anywhere in R1's record. The licensee's Documentation of Set policy, undated, indicated an RN would set up medications and would document the set up in the resident's medical record and would include date and time of set up, name of the person completing the setup, name of medication, dose, route, and time of administration. No further information was provided. TIME PERIOD TO CORRECT: 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 delegate this task to unlicensed personnel if: (1) the registered nurse has trained the	01790		

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01790	Continued From page 64 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 doses of each returned medication.	01790			

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01790	Continued From page 65 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 training and competencies for unlicensed personnel (ULP) providing medications to residents for unplanned time away from home when the licensed nurse was not available for two of two employees (ULP-B, ULP-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-B ULP-B was hired on September 15, 2019. ULP-B's employee record lacked documentation of training and competencies for unplanned time away when the RN was not available. ULP-C ULP-C was hired on January 31, 2019. ULP-C's employee record lacked documentation of training and competencies for unplanned time away when the RN was not available. On October 4, 2023, at 9:35 a.m., licensed assisted living director (LALD)/RN-A stated all ULP were trained, and competency tested on	01790			

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01790	Continued From page 66 providing medications to residents for unplanned time away but did not have documentation of the training or competencies. The licensee's Staff Requirements policy, undated, indicated before performing delegated tasks, ULP would complete training of that task and demonstrate competency either with an oral or written exam and would perform a practical skills test of the task with the RN. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790			
01830 SS=F	144G.71 Subd. 14 Renewal of prescriptions Prescriptions must be renewed at least every 12 months or more frequently as indicated by the assessment in subdivision 2. Prescriptions for controlled substances must comply with chapter 152. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to renew prescriptions at least every 12 months for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or 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).	01830			

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01830	Continued From page 67 The findings include: R1's record lacked an annual renewal of prescriber orders for medications. R1's diagnoses included seizure disorder, diabetes (disease that affects how the body uses blood sugar), and moderate mental retardation (cognitive deficits in functional and adaptive skills). R1's service plan dated December 9, 2022, indicated R1 received assistance with medication management. On October 3, 2023, at 7:23 a.m., the surveyor observed unlicensed personnel (ULP)-B administer R1's oral medications and check a blood sugar. R1's most current prescriber orders were requested, and copies of individual e-scripts were provided. The following physician orders lacked evidence of being renewed annually: - divalproex DR 250 mg; take 2 tablets (=500 mg) by mouth daily for seizure disorder; per physician order dated March 27, 2022. - Calcium/Vit D 600-400 mg-unit; take 1 tablet twice daily for bone health; per physician order dated November 25, 2022. - Vitamin D3 25 micrograms (mcg); take 3 tablets by mouth daily for bone health; per undated physician order. On October 3, 2023, at 9:34 a.m., licensed assisted living director/registered nurse (LALD/RN)-A stated R1's prescriber orders listed	01830			

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01830	Continued From page 68 above had not been renewed at least annually as required. LALD/RN-A further indicated he was not aware of this requirement. The licensee's Medication Management Program Process policy, undated, indicated all medications must have written doctor orders. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01830			
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were secure and permitted access to only authorized personnel for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	01880			

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01880	Continued From page 69 The findings include: On October 2, 2023, at 10:24 a.m. during the entrance conference, licensed assisted living director/registered nurse (LALD/RN)-A stated all medications were secured in a locked cabinet which only staff have access to it. On October 3, 2023, at 7:23 a.m. unlicensed personnel (ULP)-B was observed removing R1's medications from an unlocked cabinet in the common area office. ULP-B stated all residents weekly medications were kept in the unlocked cabinet and any over the counter (OTC) medications were also kept in the unlocked cabinet. On October 3, 2023, at 9:39 a.m. LALD/RN-A stated the main supply of medications were kept in the locked cabinet and each week he would put a week's worth of medications into the unlocked cabinet for all residents for staff to use for medication administration. LALD/RN-A further stated the OTC medications were also kept in the unsecured cabinet. Over the course of the survey, the surveyor observed residents use the common office area with the unsecured cabinet with no staff present in the area. Residents would have access to the unsecured medications in the cabinet. The licensee's Storage Of Medications policy, undated, indicated all medications would be stored in a locked container that is only accessible to staff with prior authorization. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7)	01880			

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01880	Continued From page 70 days	01880			
01910 SS=F	144G.71 Subd. 22 Disposition of medications (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 document in the resident's record the disposition of the medications as required for one of one resident (R2) upon discharge. 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	01910			

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01910	Continued From page 71 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: R2 was admitted to the licensee on June 19, 2019, and discharged to a family member's home on October 8, 2021. R2's discharge summary dated October 31, 2021, indicated all prescribed medications were sent with R2 at the time of discharge. R2's record lacked a medication disposition record at the time of discharge to include 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. On October 4, 2023, at 9:35 a.m., licensed assisted living director/registered nurse (LALD/RN)-A stated he was unaware of this requirement. The licensee's Resident Record policy, undated, indicated resident records to include a discharge summary and related documentation would be maintained for all residents. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910			

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01940	Continued From page 72	01940			
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; (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 and implement a treatment or therapy management plan to include all required content for one of one	01940			

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01940	Continued From page 73 resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: During the entrance conference on September 25, 2023, at 10:20 a.m., licensed assisted living director/registered nurse (LALD/RN)-A stated the licensee provided treatment management services to their residents. R1's diagnoses included seizure disorder, diabetes (disease that affects how the body uses blood sugar), and moderate mental retardation (cognitive deficits in functional and adaptive skills). R1's service plan dated December 9, 2022, indicated R1 received assistance with bathing, dressing, toileting, transfers, housekeeping, laundry, meals, and medication management. The service plan lacked the service of blood sugar checks. R1's physician orders dated June 9, 2023, indicated blood sugar check one time daily. On October 3, 2023, at 7:18 a.m., the surveyor observed unlicensed personnel (ULP)-B check R1's blood sugar.	01940			

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01940	Continued From page 74 R1's records lacked a treatment management plan to include the following required content for blood sugar checks: - statement of the type of service that will be provided; - 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 when a problem arose 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. On October 4, 2023, at 9:35 a.m., LALD/RN-A stated R1's record lacked a treatment management plan to include all the required content as noted above. The licensee's Individualized Treatment and Therapy Management policy, undated, indicated the RN would create a treatment and therapy management plan for residents receiving treatment services to include: - statement of services provided - document of instruction for the services provided - identifying which treatment and/or therapy will be delegated to unlicensed personnel - Procedure for notifying the RN when question or concerns arise from the service - any additional documentation that is required for the successful and safe application of that treatment or therapy	01940			

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01940	Continued From page 75 - documentation of the administration of the treatment or therapy - monitoring the treatment or therapy for possible complications or adverse reactions No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
02310 SS=I	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure care and services were provided according to acceptable health care and medical or nursing standards for one of one resident (R4) with side rails. This resulted in an immediate correction order on October 3, 2023, at 1:40 p.m. 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). The findings include:	02310		

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02310	Continued From page 76 During the entrance conference on October 2, 2023, at 10:24 a.m., licensed assisted living director/registered nurse (LALD/RN)-A stated one resident had a hospital bed with side rails. R4's diagnoses included cerebrovascular accident (stroke) with left hemiplegia (paralysis of one side of the body) and dysphagia (difficulty swallowing). R4's Service Plan dated June 9, 2022, indicated R4 received assistance with bathing, dressing, toileting, transfers, housekeeping, laundry, meals, and daily medication management. On October 3, 2023, at 8:00 a.m. R4's room was observed to have a hospital bed with bilateral upper side rails in the up position. R4's record lacked documentation of a side rail assessment, documentation of a risk versus benefits discussion, documentation of the measurements of R4's side rails, and documentation R4's side rails met the Food and Drug Administration (FDA) recommendations. On October 3, 2023, at 1:20 p.m. LALD/RN-A stated he was not aware that a hospital bed with siderails required an assessment, risk versus benefits discussion, documentation of the measurements of siderails and documentation that siderails met the FDA recommendations. The Food and Drug Administration's (FDA), A Guide to Bed Safety, dated 2000, and revised April 2010, indicated following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The	02310			

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02310	Continued From page 77 FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." The March 10, 2006, FDA Side Rail Entrapment Zones and Dimensional Recommendations indicated to reduce the risk of entrapment, zone 1 (within the rail) should not exceed 4 and 3/4 inches, zone 2 (under the rail, between rail supports or next to a single rail support) should not exceed 4 and 3/4 inches, zone 3 (between the rail and the mattress), should not exceed 4 and 3/4 inches, and zone 4 (under the rail, at the ends of the rail) should not exceed 2 and 3/8 inches or be greater than a 60 degree angle. The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, "Documentation about a resident's bed rails includes, but is not limited to: - Purpose and intention of the bed rail; - Condition and description (i.e., an area large enough for a resident to become entrapped) of	02310			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37368	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 10/04/2023
NAME OF PROVIDER OR SUPPLIER SERENDIPITOUS LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 7935 UPPER 139TH COURT WEST APPLE VALLEY, MN 55124			
(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
02310	Continued From page 78 the bed rail; - The resident's bed rail use/need assessment; - Risk vs. benefits discussion (individualized to each resident's risks); - The resident's preferences; - Installation and use according to manufacturer's guidelines; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements". Additionally, the MDH website indicated for hospital-style bed rails, the licensee must include in their documentation, the bed rail measurements and that the bed rail has not shifted and is securely attached to the bed frame per manufacturer recommendations. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate On October 4, 2023, the immediacy was removed as confirmed by email correspondence with evaluation supervisor, but non-compliance remains at a level 3/widespread (I).	02310			
03090 SS=F	144.6502, 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.	03090			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37368	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 10/04/2023
NAME OF PROVIDER OR SUPPLIER SERENDIPITOUS LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 7935 UPPER 139TH COURT WEST APPLE VALLEY, MN 55124		
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03090	Continued From page 79 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure the required notice was posted at the main entryway of the facility to display statutory language to disclose electronic monitoring activity, potentially affecting all residents in the assisted living facility, staff, and any visitors of the licensee. 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 the facility tour on October 2, 2023, at 11:00 a.m., the surveyor observed the incorrect electronic monitoring notice posted at the entrance to the licensee's facility, which read: "Security Alert 24 hour video surveillance, all activities are monitored." On October 2, 2023, at 11:54 a.m., licensed assisted living director/registered nurse (LALD/RN)-A stated he was unaware of the required verbiage on the electronic monitoring sign. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	03090			

Type: Full
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Report: 1004231150

Food and Beverage Establishment Inspection Report

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Location:

Serendipitous Living
7935 Upper 139th Court West
Apple Valley, MN55124
Dakota County, 19

Establishment Info:

ID #: 0039350
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 9526831075
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

2-201.11A

**** Priority 1 ****

MN Rule 4626.0040A The licensee must ensure that employees and conditional employees report to the person in charge information about their health as it relates to illnesses transmissible through food. A food employee or conditional employee must report to the person in charge the date of onset of symptoms such as vomiting, diarrhea, jaundice, sore throat with fever, boils or infected wounds, diagnosed illnesses such as norovirus, hepatitis A virus, Salmonella spp, Shigella spp, Shiga toxin-producing Escherichia coli or other enteric bacterial, viral, or parasitic pathogens, and if they have been exposed to, or are the suspected source of, a probable or confirmed disease outbreak within the last 30 days.

ESTABLISHMENT DOES NOT HAVE A SET EMPLOYEE ILLNESS POLICY TRAINED TO STAFF MEMBERS IN PLACE. ESTABLISH AN EMPLOYEE ILLNESS POLICY AND FULLY TRAIN ALL STAFF MEMBERS, INCLUDING SYMPTOMS, REPORTABLE DISEASES, AND EXCLUSION FROM WORK. *SEE NOTES.

Comply By: 10/03/23

4-300 Equipment Numbers and Capacities

4-302.12B

**** Priority 2 ****

MN Rule 4626.0705B Provide a readily accessible food temperature measuring device with a small diameter probe to measure the temperature in thin foods such as meat patties and fish fillets.

THERMOMETER COULD NOT BE PRODUCED DURING INSPECTION. ENSURE THERMOMETER IS READILY ACCESSIBLE AND THAT IT HAS A SMALL-DIAMETER PROBE.

Comply By: 10/03/23

Food and Equipment Temperatures

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Process/Item: AMBIENT TEMPERATURE

Temperature: <40 Degrees Fahrenheit - Location: KITCHEN REFRIGERATOR

Violation Issued: No

Process/Item: MILK

Temperature: 41 Degrees Fahrenheit - Location: KITCHEN REFRIGERATOR

Violation Issued: No

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

INSPECTION WAS CONDUCTED BY MOLLY DOUGHERTY (FPLS) IN CONJUNCTION WITH A HEALTH REGULATIONS DIVISION (HRD) SURVEY CONDUCTED BY KASSIE MARKING.

DISCUSSED:

- EMPLOYEE ILLNESS POLICY AND LOG
- HANDWASHING
- SANITIZER USE
- CLEANING/SANITIZING FOOD CONTACT SURFACES AND UTENSILS
- HIGH TEMPERATURE SANITIZING DISH MACHINE TEMPERATURE VERIFICATION
- DATE MARKING PROCEDURES
- THERMOMETER USE AND CALIBRATION
- SERVING A HIGHLY SUSCEPTIBLE POPULATION (NO RAW/UNDERCOOKED ANIMAL FOODS, NO UNPASTEURIZED JUICE, MILK, ETC)
- VOMIT/FECAL INCIDENT CLEAN UP PROCEDURES
- FOOD SOURCE
- FOOD SERVICE PROCEDURES
- PEST CONTROL
- PHYSICAL FACILITIES AND MAINTENANCE

*EMPLOYEE ILLNESS: THE EMPLOYEE ILLNESS POLICY SHOULD, AT THE MOST BASIC LEVEL, STATE THAT EMPLOYEES EXHIBITING SYMPTOMS OF DISEASE THAT IS TRANSMISSIBLE BY FOOD (I.E. VOMITING, DIARRHEA OR OTHER ACUTE GASTROINTESTINAL ILLNESS; JAUNDICE, HEPATITIS A, E.COLI, SHIGELLA, SALMONELLA, OR NOROVIRUS) MUST REPORT THESE SYMPTOMS TO THEIR EMPLOYER. EMPLOYEES EXHIBITING VOMITING, DIARRHEA, OR OTHER ACUTE GASTROINTESTINAL ILLNESS MUST BE EXCLUDED FROM WORK UNTIL THEY HAVE BEEN SYMPTOM FREE FOR A MINIMUM OF 24 HOURS. EMPLOYEE ILLNESSES MUST BE RECORDED ON EMPLOYEE ILLNESS LOG, INCLUDING DATE OF ONSET, DAYS MISSED FROM WORK, RETURN DATE, AND ALL SYMPTOMS

*REPORT WAS DISCUSSED OPERATORS OF THE FACILITY AND WITH THE NURSE EVALUATOR, KASSIE.

*FLOORS ARE LINOLEUM TILE, CEILING AND WALLS ARE SMOOTH PAINTED DRYWALL. COUNTERTOPS ARE LAMINATE AND CABINETS ARE VARNISHED WOOD WITH HALLOW BASE. ALL ARE FOUND TO BE IN GOOD CONDITION AND WILL BE MONITORED AT FUTURE INSPECTIONS. IF AT SUCH A TIME THEY ARE FOUND TO BE A CONCERN OR RISK OF CONTAMINATION, THEY WILL BE ORDERED TO BE REPLACED AND BROUGHT UP TO CODE.

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*KITCHEN HAS A 2-BASIN SINK. ONE BASIN IS DESIGNATED AS THE HANDWASHING SINK. THIS BASIN MAY ONLY BE USED FOR HANDWASHING PURPOSES.

*IF ANY RESIDENT COMPLAINS OF ILLNESS, CONTACT THE MINNESOTA DEPARTMENT OF HEALTH AND PROVIDE THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER TO THE RESIDENT. THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER IS 1-877-366-3455.

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 1004231150 of 10/03/23.

Certified Food Protection Manager SALINA YANN

Certification Number: FM11340 Expires: 06/04/25

Signed: _____

SALINA YANN
CFPM

Signed: Molly Dougherty

Molly Dougherty
Public Health Sanitarian
Metro District Office
651-201-3978
molly.dougherty@state.mn.us