



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

December 11, 2024

Licensee
Divine Home Care Services LLC
3307 O'Henry Road
Brooklyn Center, MN 55429

RE: Project Number(s) SL36163015

Dear Licensee:

On November 6, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the July 25, 2024, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink that reads 'Casey DeVries'.

Casey DeVries, Supervisor
State Evaluation Team
Email: casey.devries@state.mn.us
Telephone: 651-201-5917 Fax: 1-866-890-9290

JMD



Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF CONDITIONAL LICENSE

Electronically Delivered

August 20, 2024

Licensee

Divine Home Care Services LLC
3307 O'Henry Road
Brooklyn Center, MN 55429

RE: Conditional License Number 414753
Health Facility Identification Number (HFID) 36163
Project Number(s) SL36163015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 25, 2024, for the purpose of assessing compliance with state licensing statutes. Based on the survey results you were found not to be in substantial compliance with the laws pursuant to Minnesota Statutes, Chapter 144G.

As a result, pursuant to Minn. Stat. § 144G.20, MDH is issuing a 90-day conditional license due to expire on **November 18, 2024**.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement.

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

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

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

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

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

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

MDH may assess fines based on the level and scope of the orders outlined below. The total amount of **potential** fines that may be assessed related to these correction orders is \$9,000.00. **MDH is not imposing these fines against your license at this time.**

St - 0 - 0470 - 144g.41 Subdivision 1 - Minimum Requirements - \$3,000.00

St - 0 - 0495 - 144g.41 Subd. 1 (14) - Minimum Requirements - \$3,000.00

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

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 and immediately correct any reissued orders outlined on the state form; however, plans of correction are not required to be submitted for approval. **If corrections are not made, MDH may impose fines as described above and in accordance with Minnesota Statutes 144G.**

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

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>

CONDITIONAL LICENSE ISSUED:

MDH will issue Divine Home Care Services LLC a conditional assisted living facility license for 90 calendar days from the date of this notice. At an unannounced point in time, within the 90 calendar days, MDH will conduct a follow-up survey, as defined in Minn. Stat. § 144G.30, Subd. 6. Based on the results of the follow-up survey,

MDH will determine if Divine Home Care Services LLC is in substantial compliance.

The following conditions apply on the conditional assisted living facility license:

- a. **No new substantiated maltreatment allegations:** If any new investigations begin in the conditional license period, and the allegations are substantiated, MDH may pursue additional enforcement actions up to and including immediate temporary suspension and revocation of the license.
- b. **No new admissions:** Divine Home Care Services LLC will not admit any new residents under its conditional assisted living facility license until MDH removes the “no new admissions” condition. Divine Home Care Services LLC must provide the Department:
 - i. A list of the names and birthdates of any individuals Divine Home Care Services LLC is currently in the process of admitting. These individuals will be able to continue the admittance process.
 - ii. A list of all current residents by location including:
 - 1. Name and birthdate of each resident
 - 2. Physical location of each resident
 - 3. Current payment source for services
 - 4. If Elderly Waiver, the name and contact information of the care coordinator/case manager
 - 5. If the resident is not able to make informed decisions, the name of their representative and how to contact the representative
- c. **Consultant:** Divine Home Care Services LLC will contract with an RN to provide consultation concerning all resident(s) to whom Divine Home Care Services LLC provides licensed assisted living services under the conditional license. The consultant must have access to all resident(s) receiving services from Divine Home Care Services LLC. The consultant will conduct initial and ongoing evaluations of the provider. Direct resident observation may be required based on the consultant’s judgement or at the discretion of MDH. The RN must not have any affiliation with Divine Home Care Services LLC and MDH must review the RN’s credentials and approve the selection. Divine Home Care Services LLC is responsible for the expense of the contract with the RN. The main purpose of the consultant is to provide guidance to Divine Home Care Services LLC in an effort to help Divine Home Care Services LLC align their practices with the requirements of Minn. Stat. §§ 144G.01 – 144G.9999 and to provide oral and written reports to MDH noting progress toward substantial compliance and/or concerns about observations. Divine Home Care Services LLC will develop and implement policies, procedures, and processes specific to the offered services in accordance with the guidance provided by the consultant to ensure ongoing monitoring and substantial compliance with statutory requirements.
- d. **Reports:** The RN consultant will provide MDH with regular reports at intervals specified by MDH. Reports will begin on a weekly basis until MDH notifies Divine Home Care Services LLC and the RN consultant about a change. Each report will be electronically submitted to Casey DeVries, Surveyor Supervisor, State Evaluation Team, Health

Regulation Division, at Casey.DeVries@state.mn.us. Casey DeVries can be reached at 651-201-5917 (office) with questions about reports. The content of the reports will include information such as:

- i. Progress towards correction of orders;
 - ii. Observations of staff delivering assisted living services and the level of competency observed;
 - iii. Conversations with residents and family members about satisfaction with assisted living services;
 - iv. Conversations with staff about their level of knowledge about the tasks they perform, the people they serve and the health professionals who delegate to them;
 - v. Overall impressions about the quality of the assisted living services delivered;
 - vi. Overall impressions about the dignity with which the residents and their family members are treated;
 - vii. Concerns; and
 - viii. Any other information requested by the Department or considered important by the RN consultant(s).
- e. Monitoring visits:** MDH may make unannounced monitoring visits to assess the progress of Divine Home Care Services LLC to correct the violations cited during the survey as well as to determine the overall practice of Divine Home Care Services LLC in meeting the needs of the people it serves. In addition, the Office of Ombudsman for Long-Term Care (OOLTC) may also make unannounced monitoring visits to determine the level of satisfaction of those people who receive licensed assisted living services. The OOLTC will share their findings with MDH.
- f. Follow-up survey:** At the time of the follow-up survey, MDH may pursue additional enforcement actions, up to and including immediate temporary suspension or revocation of the license if MDH identifies any level 3 or 4 violations or widespread care related violations.
- g. Corrective Action Plan:** Divine Home Care Services LLC will develop and work within a corrective action plan (CAP). The CAP is a working document that includes at least the following information:
- i. A statement of the concern
 - ii. A description of what will happen to correct the concern
 - iii. A target date for when each correction will be complete
 - iv. Who is responsible to make sure it happens
 - v. Current status of correction work
 - vi. Description of a plan to monitor and ensure ongoing substantial compliance for each corrected order

RESULTS OF FOLLOW-UP EVALUATION DURING THE CONDITIONAL LICENSE PERIOD:

MDH will determine if Divine Home Care Services LLC is in substantial compliance based on the results of the follow up survey. MDH will make this determination within the 90-day conditional license period. If MDH determines Divine Home Care Services LLC is in substantial compliance on the follow up survey, MDH will remove the conditions from Divine Home Care Services LLC's assisted living facility license, and Divine Home

Care Services LLC will correct any outstanding violations identified during the survey. If Divine Home Care Services LLC is not in substantial compliance on the follow-up survey, MDH may take additional enforcement action, up to and including immediate temporary suspension and revocation, as authorized by Minn. Stat. § 144G.20.

REQUESTING A HEARING:

Pursuant to Minn. Stat. §144G.20, Subd. 18, the licensee may appeal an action against the license under this section. The licensee must request a hearing no later than 15 business days after licensee receives notice of the action. To submit a hearing request, please visit

<https://forms.web.health.state.mn.us/form/HRD-Appeals-Form>.

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 Casey DeVries directly at: 651-201-5917.

Sincerely,

A handwritten signature in black ink that reads "Rick Michals". The signature is written in a cursive, slightly slanted style.

Rick Michals, J.D.

Executive Regional Operations Manager

**Minnesota Department of Health
Health Regulation Division**

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36163	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/25/2024
NAME OF PROVIDER OR SUPPLIER DIVINE HOME CARE SERVICES LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3307 O'HENRY ROAD BROOKLYN CENTER, MN 55429		
(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: SL36163015-0 On July 22, 2024, 2024, through, July 25, 2024, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were three residents all of whom received services under the provider's Assisted Living Facility license. An immediate order for correction was identified on July 23, 2024, issued for SL36163015-0, tag identification 0470. An immediate order for correction was identified on July 23, 2024, issued for SL36163015-0, tag identification 1290. An immediate order for correction was identified on July 23, 2024, issued for SL36163015-0, tag identification 0830.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. 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 SUBDIVISION 1-3.		

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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0 000	Continued From page 1 An immediate order for correction was identified on July 24, 2024, issued for SL36163015-0, tag identification 0495. On July 25, 2024, the immediacy of correction order 1290 was removed, however non-compliance remained, and the scope and level remained unchanged. The immediacy of correction orders 0470, 0830, and 0495 were not removed at the time of the survey exit on July 25, 2024.	0 000			
0 250 SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records,	0 250			

Minnesota Department of Health

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0 250	Continued From page 2 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 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	0 250			

Minnesota Department of Health

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0 250	Continued From page 3 and procedures as required with records reviewed. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on July 22, 2024, at 9:28 a.m., owner/unlicensed personnel (O/ULP)-B stated the licensee's employees in charge of the facility were familiar with the assisted living regulations and the licensee provided medication and treatment management services. The licensee's Application for Assisted Living License, section titled Official Verification of Owner or Authorized Agent, (page four and five of the application), identified, I certify I have read and understand the following: [a check mark was placed before each of the following]: - I have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section] 144G.45, my building(s) must comply with subdivisions 1-3 of the section, as applicable section Laws 2020, 7th Spec. [special] Sess [session]., chpt. [chapter] 1. art. [article] 6, sect. 17. - I have read and fully understand Minn. Stat.	0 250			

Minnesota Department of Health

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0 250	Continued From page 4 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 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	0 250			

Minnesota Department of Health

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0 250	Continued From page 5 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 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 six was electronically signed by O/ULP-B on November 13, 2023. The licensee had an assisted living license issued on March 1, 2024, with an expiration date of February 28, 2025. The licensee failed to ensure the following	0 250			

Minnesota Department of Health

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0 250	Continued From page 6 policies and procedures were developed and/or implemented: - conducting and handling background studies on employees; - orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; - 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; - conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards; - medication and treatment management; - supervision of unlicensed personnel performing delegated tasks. On July 24, 2024, at 1:51 p.m., O/ULP-B confirmed the licensee provided assisted living services but failed to implement corresponding policies and procedures, as required. As a result of this survey, the following orders were issued 0470, 0495, 0580, 0650, 0660, 0680, 0780, 0790, 0800, 0810, 0830, 0910, 1290, 1370, 1380, 1500, 1530, 1620, 1650, 1760, 1890, 1910, and 2320, 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	0 250			

Minnesota Department of Health

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0 250	Continued From page 7 (21) days	0 250			
0 470 SS=H	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure that one or more persons were available 24 hours per day, seven days per week, who are responsible for	0 470			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36163	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/25/2024
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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
0 470	Continued From page 8 responding to the requests of residents for assistance with health or safety needs. This affected two of three residents (R1, R2). 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 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 admitted to the licensee on March 8, 2021, and began receiving assisted living services. R1's diagnoses included anxiety, depression, and schizoaffective disorder (a mental disorder in which a person experiences a combination of symptoms of schizophrenia and mood disorder). R1's service plan signed March 8, 2022, indicated R1 received assistance with medication administration, laundry, housekeeping, daily safety checks, and cues with dressing, oral care, hair care, grooming, and bathing. R2 R2 admitted to the licensee on November 10, 2022, and began receiving assisted living services. R2's diagnoses included schizophrenia (a mental disorder characterized by reoccurring episodes of psychosis that are correlated with a general	0 470			

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0 470	Continued From page 9 misperception of reality), borderline intellectual functioning (a person who has below average cognitive abilities), and alcohol use disorder. R2's service plan signed November 10, 2022, indicated R2 received assistance with mediation administration, laundry, housekeeping, assistance with bathing, daily safety checks, and cues with dressing, oral care, hair care, and grooming. On July 22, 2024, at 10:12 a.m., clinical nurse supervisor (CNS)-C stated the licensee did not have a staffing plan evaluated twice per year and they were "working" on the requirement. Owner/unlicensed personnel (O/ULP)-B stated they did not have a staffing plan and they inquired what a staffing plan entailed. On July 23, 2024, at 6:45 a.m., the surveyor entered the facility and was greeted by unlicensed personnel (ULP)-F. ULP-F stated all residents were sleeping. ULP-F assisted the surveyor to obtain documentation from a locked office. The surveyor then observed ULP-F place a call to an unknown individual on a cellular phone. ULP-A stated there was a surveyor at the facility and asked the unknown individual if they were still sleeping. The surveyor was unable to hear more of the phone call because ULP-F walked to a different level of the facility. On July 23, at 6:58 a.m., ULP-F stated they were "leaving the facility now." The surveyor inquired who was going to be taking over. ULP-F stated housing manager/unlicensed personnel (HM/ULP)-A "was coming". The surveyor heard the door close from the second level of the facility. The surveyor then walked upstairs to the second level of the facility to greet the next	0 470			

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0 470	Continued From page 10 employee. The surveyor observed ULP-F enter a vehicle on the passenger side and drive away from the driveway at 6:59 a.m. The surveyor observed the entire facility with the exception of R1, R2, and R3's rooms and observed no employees located within the facility. On July 23, 2024, at 7:11 a.m., the surveyor observed a car pull into the licensee's driveway. On July 23, 2024, at 7:12 a.m., HM/ULP-A entered the facility. HM/ULP-A stated ULP-F had an emergency. The surveyor inquired what the emergency was. HM/ULP-A stated ULP-F had a medical appointment their daughter was taking them to. HM/ULP-A stated ULP-F called them, and they received report on the residents. HM/ULP-A stated they had instructed HM/ULP-A to stay at the facility until they arrived however, they believed ULP-F left because they did not want to miss their appointment. HM/ULP-A stated residents had not been left unattended at the facility before and this only occurred due to an emergency. The surveyor inquired what their plan was if a staff member had an emergency and needed to leave the facility. HM/ULP-A stated ULP were to call the supervisor, administrator, or nurse and one of them would come into the facility to assist. HM-ULP-A stated the employee should wait at the facility until another staff member arrived at the facility. On July 23, 2024, at 7:44 a.m., CNS-C stated the licensee staffed one person per shift to meet the needs of the residents in the facility. CNS-C stated they were to have an employee in the facility 24 hours per day. CNS-C stated staff were trained if they had an emergency, they would contact another staff member and wait at the facility until that staff member arrived.	0 470			

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0 470	Continued From page 11 On July 28, 2024, at 8:37 a.m., O/ULP-B apologized for the employee leaving prior to another employee showing up at the facility. O/ULP-B stated, "you hire, and you hope that your training they follow." O/ULP-B stated it was unfortunate ULP-F did not follow the training. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate IMMEDIATE ORDER AMENDED: Following the issuance of the immediate correction order on July 23, 2024, at 9:40 a.m., at 10:52 a.m., HM/ULP-A stated R3 spent the night at a family member's home and was not at the facility the morning of June 23, 2024. As a result, the scope of the correction order was changed from widespread to pattern. In addition to the information indicated above, the licensee failed to develop and implement a written staffing plan that included an evaluation completed by the CNS (as indicated in Minnesota Administrative Rule 4659.0180) at least twice a year. The findings include: On July 22, 2024, at 10:12 a.m., the surveyor inquired if the licensee implemented a staffing plan that was evaluated twice per year by the CNS. CNS-C stated, "we have not done this" and inquired what the staffing plan requirement was. O/ULP-B stated, "we do not have that." TIME PERIOD FOR CORRECTION: Seven (7) days	0 470			

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0 495 SS=I	144G.41 Subd. 1 (14) Minimum Requirements (14) provide staff access to an on-call registered nurse 24 hours per day, seven days per week This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure staff had access to a registered nurse (RN) twenty-four (24) hours per day, seven (7) days per week. This affected all residents and staff. 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: R1 R1 admitted to the licensee on March 8, 2021, and began receiving assisted living services. R1's diagnoses included anxiety, depression, and schizoaffective disorder (a mental disorder in which a person experiences a combination of symptoms of schizophrenia and mood disorder). R1's service plan signed March 8, 2022, indicated R1 received assistance with medication administration, laundry, housekeeping, daily safety checks, and cues with dressing, oral care, hair care, grooming, and bathing.	0 495			

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0 495	Continued From page 13 R1's Medication Profile dated March 8, 2023, indicated ULP should call a nurse when medication side effects were observed or when R1 complained of pain. R1's Service Recap Summary- Month dated July 2024 indicated the licensee was monitoring R1 for agitation, anxiety, elopement, physical aggression, verbal aggression, and auditory hallucinations. R2 R2 admitted to the licensee on November 10, 2022, and began receiving assisted living services. R2's diagnoses included schizophrenia (a mental disorder characterized by reoccurring episodes of psychosis that are correlated with a general misperception of reality), borderline intellectual functioning (a person who has below average cognitive abilities), and alcohol use disorder. R2's service plan signed November 10, 2022, indicated R2 received assistance with mediation administration, laundry, housekeeping, assistance with bathing, daily safety checks, and cues with dressing, oral care, hair care, and grooming. R2's Medication Profile dated February 13, 2023, indicated ULP should call a nurse when medication side effects where observed. R3 R3 admitted to the licensee on November 1, 2022, and began receiving assisted living services. R3's diagnoses included hard of hearing,	0 495			

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0 495	Continued From page 14 cognitive impairment, glaucoma, and history of alcohol abuse. R3's service plan signed November 1, 2021, indicated R3 received assistance with mediation administration, laundry, housekeeping, daily safety checks, and cues with dressing, oral care, hair care, grooming, and bathing. R3's Medication Profile dated November 1, 2022, indicated ULP should call a nurse when medications side effects were observed and when R3 reported pain. On July 22, 2024, at 9:28 a.m., during the entrance conference, owner/unlicensed personnel (O/ULP)-B stated clinical nurse supervisor (CNS)-C worked at the licensee's facility five hours every two weeks and was on call 24 hours per day. O/ULP-B stated CNS-C was a full-time employee at a different care facility not associated with the licensee. O/ULP-B stated they had reached out to a previous nurse to offer them a position as a RN however, "she said she would think about it." The surveyor inquired if CNS-C could answer calls from ULP if they needed assistance while CNS-C worked at their other job. O/ULP-B stated CNS-C responded via text message and would call the ULP back on the phone when they were on their break. O/ULP-C stated CNS-C came to the facility during off hours when they were needed and there had never been an issue with getting ahold of CNS-C. O/ULP-B stated CNS-C normally returned phone calls within 15 to 30 minutes. On July 22, 2024, at 9:46 a.m., during the entrance conference, CNS-C stated they were a full-time day shift nursing manager at a different facility not associated with the licensee. CNS-C	0 495			

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0 495	Continued From page 15 stated their shift ended at 4:00 p.m. CNS-C stated they typically received a text message from the ULP and then they call them back. CNS-C stated if they took a vacation, it was only over a weekend, and they always took their phone with them to answer calls. CNS-C stated if someone readmitted on a weekend when they were on vacation, they would complete a phone assessment and then when they returned from vacation, they would complete an in-person assessment. CNS-C stated they returned phone calls within 15 to 30 minutes after receiving a text message. In addition, CNS-C stated they "never mix two jobs, when I am on break, I check, and I respond to it." On July 22, 2024, at 10:57 a.m., CNS-C stated they managed a transitional care unit and were responsible for resident care plans, falls, risk management, medication cart audits, staff, wound care, and when "short staffed" they would work on a medication cart. On July 24, 2024, at 7:26 a.m., the surveyor called CNS-C via phone. The surveyor left a voice message to call back as soon as possible. On July 24, 2024, at 8:24 a.m., the surveyor called CNS-C via phone. The surveyor left a voice message to call back as soon as possible. On July 24, 2024, 8:31 a.m., the surveyor asked O/ULP-B to call CNS-C and tell them to call the surveyor. On July 24, 2024, at 8:34 a.m., O/ULP-B stated CNS-C was in a meeting and they would call back as soon as they could. On July 24, 2024, at 8:40 a.m., the surveyor	0 495			

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0 495	Continued From page 16 asked to observe O/ULP-B's text message correspondence with CNS-C. The surveyor observed the following text message: "[surveyor] called me but I'm in a meeting tell her I [sic] call her shortly, please." On July 24, 2024, at 10:28 a.m., the surveyor requested housing manager/unlicensed personnel (HM/ULP)-A call CNS-C using their phone. CNS-C answered the call and the surveyor requested to complete an interview with them. CNS-C stated they had five minutes because they were "busy" completing wound rounds. The surveyor began to ask questions to CNS-C at 10:31 a.m. At 10:33 a.m., during a question, the surveyor could no longer hear CNS-C, and CNS-C did not respond to the surveyor's question. HM/ULP-A stated the surveyor was on hold. At 10:35 a.m., HM/ULP-A stated CNS-C texted and said they were in the middle of something. O/ULP-B stated the surveyor could try to set up a time after 4:00 p.m., because CNS-C was more available at that time. At 10:41 a.m., HM/ULP-A stated CNS-C hung up (disconnected) the phone call. On July 24, 2024, at 10:48 a.m., HM/ULP-A stated CNS-C texted and they were completing wound rounds with a doctor. On July 24, 2024, at 10:49 a.m., CNS-C called HM/ULP-A's phone and completed an interview with the surveyor. On July 24, 2024, at 12:51 p.m., the surveyor inquired what CNS-C would do if ULP called them multiple times and they were at their other place of employment. CNS-C stated they would be able to respond by text and when it was their break time, they would call them back via phone	0 495			

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0 495	Continued From page 17 because it was not on company time. CNS-C stated if the situation was urgent like a fall they would instruct the ULP to send them to the hospital. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	0 495			
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to 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 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	0 580			

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0 580	Continued From page 18 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 July 22, 2024, at 10:21 a.m., during the entrance conference, clinical nurse supervisor (CNS)-C stated the licensee did not have a QMP. Owner/unlicensed personnel (O/ULP)-B stated they did not have a formal QMP that was documented however, they communicated with each other when issues occurred within the facility. On July 24, 2024, at 10:57 a.m., CNS-C stated they were not sure why the licensee did not have a QMP however, it was something they could work on putting into place. CNS-C stated they were not aware that a QMP was needed. The licensee's undated Quality Management Program policy indicate the licensee had established a quality improvement program on the organization's size and appropriate to the types of services provide to assure that effective, comprehensive, and appropriate plans were operational for all the clients [residents] within the organization. In addition, the licensee would maintain documents of the QMP for at least two years and would provide the documents to the commissioner at a time of survey or investigation when requested. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 580			

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0 650	Continued From page 19	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 interview and record review, the licensee failed to ensure employee records contained the required content for three of three employees (housing manager/unlicensed personnel (HM/ULP)-A, owner/unlicensed personnel (O/ULP)-B, unlicensed personnel (ULP)-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 650			

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0 650	Continued From page 20 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: HM/ULP-A HM/ULP-A was hired on March 28, 2024, to oversee day to day operations of the facility and to provide direct care services to residents. HM/ULP-A's employee record lacked the following required content: -record of orientation to include: - assisted living bill of rights; - handling of resident complaints; - consumer advocacy services; and - principles of person-centered planning/service delivery. - record of training: - documentation for all services provided; - dressing and assisting with toilet; - basic nutrition, meal preparation, food safety, and assistance with eating; - preparation of modified diets as ordered by a licensed health professional; - observation, reporting, and documenting of resident's status; and - reading and recording temperature, pulse. - records of competency evaluations: - vital signs; and - unplanned times away. - 30 day supervision. O/ULP-B O/ULP-B opened the licensee's company in 2018.	0 650			

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0 650	Continued From page 21 O/ULP-B began providing assisted living services on August 1, 2021. O/ULP-B oversaw the licensee's operations and provided direct care services to residents. O/ULP-B's record lacked the following required content: - training and competency evaluation for unplanned times away; and - documentation of annual performance reviews that identify areas of improvement needed and training needs. ULP-E ULP-E was hired on March 1, 2021, to oversee the licensee's operations and to provide direct care services to residents. ULP-E's employee record lacked the following required content: - training and competency evaluation for unplanned times away; and - documentation of annual performance reviews that identify areas of improvement needed and training needs. On July 24, 2024, at 9:22 a.m., O/ULP-B stated performance evaluations were completed annually, were conducted verbally, and O/ULP-B and licensed assisted living director (LALD)-D administered the performance evaluations however, they did not document the verbal discussions with the employees. On July 24, 2024, at 9:36 a.m., O/ULP-B stated the surveyor would not find the orientation topics listed above in HM/ULP-A's record. O/ULP-B stated they knew there were employee record issues. O/ULP-B stated they were going to work on the employee records last week however, they	0 650			

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0 650	Continued From page 22 put it off. On July 24, 2024, at 9:47 a.m., O/ULP-B stated HM/ULP-A was trained on the training topics listed above from a YouTube video. On July 24, 2024, at 9:55 a.m., O/ULP-B stated the licensee completed 30-day supervisions for ULP. O/ULP-B stated they completed a 30-day supervision with HM/ULP-A verbally. O/ULP-B stated, "I did not document for file, but I know I am supposed to." On July 24, 2024, at 9:56 a.m., O/ULP-B stated they trained all employees on unplanned times away for medication by watching a You Tube video, completing an in-person training, and ULP completed a return demonstration. On July 24, 2024, at 10:26 a.m., HM/ULP-A stated they received all of the orientation, training, and competency evaluations listed above. HM/ULP-A stated they watched You Tube videos, completed in person training, and completed a return demonstration to their supervisor. In addition, HM/ULP-A stated they received a 30-day supervision related to medication administration and other tasks they completed in the facility. The licensee's undated Employee Records policy indicated the licensee would maintain a current record of each paid employee. The employee record would include evidence of licensure or certifications, orientation, required annual training, infection control, competency evaluation, performance evaluations, health screenings, background study, and job descriptions. No further information provided.	0 650			

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0 650	Continued From page 23	0 650			
0 660 SS=E	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 licensee failed to maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), which included a two-step tuberculin skin test (TST) or other evidence of TB screening such as a blood test for two of three employees (housing manager/unlicensed personnel (HM/ULP)-A, unlicensed personnel (ULP)-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	0 660			

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0 660	Continued From page 24 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: The facility TB risk assessment form dated July 3, 2024, indicated the facility was at a low risk for TB transmission. HM/ULP-A HM/ULP-A was hired on March 28, 2024, to oversee day to day operations of the facility and to provide direct care services to residents. HM/ULP-A's employee record included baseline TB screening tool titled T.B. Screening dated March 28, 2024. In addition, HM/ULP-A record included a one-step TST completed on July 21, 2024. ULP-E's record lacked evidence that a second step TST was completed. ULP-E ULP-E was hired on March 1, 2021, to oversee the licensee's operations and provided direct care services to residents. ULP-E's employee record included baseline TB screening tool titled New Hire Health & Mantoux Screen dated February 22, 2021. The document's two step TST section was not completed. ULP-E's record lacked evidence that a baseline TB screening was completed. On July 24, 2024, at 9:13 a.m., owner/unlicensed personnel (O/ULP)-B stated the licensee had a	0 660			

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0 660	Continued From page 25 contract with the local pharmacy to conduct TST on new employees. O/ULP-B stated they were responsible for monitoring TB base line screening along with licensed assisted living director (LALD)-D. O/ULP-B stated they were not aware that it was required to have two step TST completed for baseline screening. On July 24, 2024, at 10:31 a.m., clinical nurse supervisor (CNS)-C stated employees went to a clinic to receive a TST and returned the paperwork to the licensee when the test was completed. CNS-C stated administration monitored the employee TB paperwork however, administration would make them aware when results were returned to review them. CNS-C stated they "sometimes" reviewed the results, and they did not remember if they reviewed HM/ULP-A or ULP-E TST results. CNS-C stated a TST required two steps. The CDC's document titled Baseline TB Screening and Testing dated December 15, 2023, recommended all health care personnel should be screened for TB upon hire and the TB screening process included: - a baseline individual TB risk assessment; - TB symptom evaluation; and - a TB test which could include TB blood test or TB skin test. The licensee's undated 4555.1200 Housing with Service Staff Health policy, indicated TB testing would be completed upon hire and if an employee completed a two-step TST the employee may start employment however, the second step TST must be completed within 21 days. No further information was provided.	0 660			

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0 660	Continued From page 26	0 660			
	TIME PERIOD FOR CORRECTION: Twenty-one (21) days				
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. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a written emergency preparedness plan (EPP) with all the required content as defined in Appendix Z. This had the potential to affect all residents, staff, and visitors.	0 680			

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0 680	Continued From page 27 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's emergency disaster preparedness plan lacked evidence of the following required content: - annual update; - hazard vulnerability risk assessment; - considered emerging infectious diseases; - developed strategies for addressing facility and community based risks; - a missing resident plan and quarterly review of the missing resident plan; - emergency preparedness (EP) program patient population; - process for EP collaboration; - subsistence needs for staff and patients to include sewage, waste disposal, and temperatures; - policies and procedures for evacuation including, transportation and evacuation locations; - policies and procedures for medical documents; - policies and procedures for volunteers; - arrangements with other facilities; - roles under waiver declared by secretary; - communication plan; - emergency officials contact information; - methods for sharing information; and - long term care family notifications.	0 680			

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0 680	Continued From page 28 On July 24, 2024, at 8:57 a.m., owner/unlicensed personnel (O/ULP)-B stated the licensee hired a consultant to create the EPP and licensed assisted living director (LALD)-D and O/ULP-B reviewed the emergency preparedness plan yearly. O/ULP-B stated they did not know they needed to document the EPP reviews and did not have documentation for the EPP reviews. O/ULP-B stated they did not address any of the topics listed above. O/ULP-B stated they were not aware of the requirements, and they relied on their consultant for this document. The licensee's undated Emergency Preparedness policy indicated the licensee would have an identified plan in place to assure the safety and well-being of clients [residents] and staff during period of emergency or disaster that disrupts services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity	0 780			

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0 780	Continued From page 29 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: Based on observation and interview, the licensee failed to provide working smoke alarms in the home and failed to provide smoke alarms that are interconnected so that the activation of one alarm causes all alarms in the home to operate for proper notification. This has the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On July 25, 2024, from approximately, 9:30 a.m. to 11:30 a.m., survey staff toured the home with the unlicensed personnel (ULP)-E. During the	0 780			

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0 780	Continued From page 30 tour, survey staff observed the following upon testing the home's smoke alarms: -A missing smoke alarm in the upper-level hallway outside of resident sleeping rooms. The finding was evident as there were exposed wires in the housing on the wall without a smoke alarm and the ULP-E immediately went to locate a smoke alarm and installed it. In addition, the ULP-E tested the smoke alarm after re-installation, and the alarm sounded local. It was not interconnected to activate the other smoke alarms to operate throughout as required. - The smoke alarms in the home were not interconnected so the actuation of one alarm would cause all alarms to operate and sound throughout as required. The deficient finding was evident when inside resident sleeping rooms 2, 3, and 4, and on the lower-level hallway, the smoke alarms were tested and each smoke alarm sounded local. -Inside resident sleeping room 1 (master bedroom), the smoke alarm failed to operate when tested as there was no sound. Survey staff observed that the home had multiple different brands of hardwired and battery-operated smoke alarms. Survey staff explained that the different brands of smoke alarms may not be compatible with the interconnection of smoke alarms, and they need to replace or reach out to the manufacturer for guidance for proper installation so that when one alarm is activated, all smoke alarms in the world operate and sound (interconnected) throughout the home. The above deficient findings were verified by the ULP-E at the time of discovery accompanying the home tour.	0 780			

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0 780	Continued From page 31 On July 25, 2024, at approximately 11:45 a.m., survey staff explained the above deficient findings to the ULP-E during the exit interview. The ULP-E understood and acknowledged the findings and had no further questions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780			
0 790 SS=B	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 to provide the proper installation of the lower-level portable fire extinguisher. This had the potential to directly affect residents and staff. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not	0 790			

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0 790	Continued From page 32 affect health or safety) 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: On July 25, 2024, from approximately, 9:30 a.m. to 11:30 a.m., survey staff toured the home with the unlicensed personnel (ULP)-E. During the tour, survey staff observed the portable fire extinguisher located in the lower-level sunroom was incorrectly mounted at a height of 70 inches above the floor. The maximum height allowed by the state standard for extinguishers weighing less than 40 pounds at 60 inches (5 feet) above the floor. The above deficient finding was verified by the ULP-E at the time of discovery accompanying the home tour. On July 25, 2024, at approximately 11:45 a.m., the ULP-E acknowledged the above deficient finding during the interview. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 790			
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the	0 800			

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0 800	Continued From page 33 residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment of the facility in a continuous state of good repair and operation. This has the potential to directly affect the health, safety, and well-being of the residents, visitors, and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On July 25, 2024, from approximately, 9:30 a.m. to 11:30 a.m., survey staff toured the home with the unlicensed personnel (ULP)-E. During the tour, survey staff observed the following: PEST CONTROL -Mouse droppings were observed behind the bed board and the sofa chair inside the lower-level resident sleeping room 4. -Mouse droppings were observed in the lower-level corner common area couch. -Mouse droppings were observed inside the kitchen sink cabinet.	0 800			

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0 800	Continued From page 34 Survey staff pointed the mouse droppings to the ULP-E and asked the ULP-E about the cleaning schedule of the lower-level rooms and pest control. The ULP-E responded that they clean the carpet frequently. In addition, survey staff pointed more mouse droppings inside the kitchen sink cabinet on the main level floor to the ULP-E. The ULP-E visually and verbally verified the findings and explained to the survey staff they are currently working on hiring a pest control company. At 11:30 a.m., the findings were verified when survey staff observed the ULP-E place a call to the pest control company and left a voicemail for a returned phone call. The ULP-E explained to survey staff that the last time they had pest control treatment was around November 2020, but they had recently contacted a pest control professional for a quote in May (dated, May 15, 2024) for pest control, However, they had not signed the contract with this recent company because it was a lot of money. Survey staff explained to the ULP-E that they must protect the home from unwanted animals and insects for basic sanitation and safety of the residents and staff. COOLING SYSTEM -The licensee failed to maintain the air conditioning (AC) unit in working order. The finding was evident when the ULP-E turned the thermometer setting to cooling and the AC unit failed to kick on. Furthermore, ULP-E and survey staff went outside, and verified AC fans did not spin. The finding was verified when the ULP-E immediately contacted their service/maintenance company and showed survey staff an email that they had secured an appointment for 8:00 a.m. on July 26, 2024, for repair.	0 800			

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0 800	Continued From page 35 -The furnace filter was filled with thick dirt and debris. In addition, an incorrect size filter, 1-inch, was used rather than the designed 4-inch filter. The ULP-E stated he thought the service/maintenance was here but couldn't remember the date of the last time. LOWER-LEVEL LAUNDRY CLOSET -The 2-inch abandoned standpipe (drain) inside the closet next to the laundry sink was not capped to prevent sewer gas from continuously entering the room and building environment. The ULP-E explained that the standpipe used to serve a water softener discharge, but they no longer have one. The ULP-E also commented that they no longer use the washer and dryer, but the nearly laundromat for washing clothes. -Large amounts of dishware and kitchen equipment were improperly stored on the floor inside the laundry closet and inside the furnace closet. -The water meter was blocked from ready access in case of emergency with big bags of clothes/belongings, stacks of dishes on the floor, kitchen equipment, and mopping equipment in front of the meter. -The electric panel was blocked from ready access in case of emergency with a dryer appliance in front of the panel. FLOORING and WALLS -ALL carpet flooring in the home was worn out, heavily soiled, and stained throughout including the hallway on the upper level to the resident sleeping rooms, the steps from the main level to the upper level, the lower level common (living) room, lower- level sleeping room 4, the hallway, the steps from the lower level to the main level floor, and the staff office. The ULP-E agreed that the carpet flooring needed to be replaced and	0 800			

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0 800	Continued From page 36 stated that shampooing the carpet may not be adequate but they may try. -Lack of cleaning on the walls and the floor wood trims inside the upper-level resident sleeping room 3. This was evident as survey staff observed dirty and stained walls and wood trims near the flooring. -The folded closet door inside resident room 4 was missing hardware to secure the door in place. EXTERIOR of BUILDING -No approved smoke receptacle was provided at the designated smoking area in the backyard. Survey staff observed an unapproved opened 2-inch diameter size steel-type 18-inch-tall cylinder. -The home's roof gutter system was not maintained for proper drainage of rainwater. Small garden weeds were visible on the front perimeter of the roof gutter system indicating the gutter had not been cleaned out recently and was full of dirt/debris. When asked about the gutter cleaning, the ULP-E could not remember the last time the gutter system was cleaned out. Survey staff explained that the roof gutter must be cleaned out and maintained for proper roof drainage to protect the home. The ULP-E verified the finding and agreed that the gutter needed to be cleaned. -The home's wood-type sidings were not maintained. Survey staff observed the siding painting was faded and siding pieces were deteriorating including chipping pieces near the day room. The above deficient findings were verbally and/or visually verified by the ULP-E at the time of discovery accompanying the tour.	0 800			

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0 800	Continued From page 37 On July 25, 2024, at approximately 11:45 a.m., survey staff explained the above deficient findings to the ULP-E during the exit interview. The ULP-E understood and acknowledged the findings and had no further questions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800			
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at	0 810			

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0 810	Continued From page 38 least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, document and record review, and interview, the licensee failed to provide all required contents on the fire safety and evacuation plan, the minimum number of fire evacuation drills, and the required minimum training of staff and residents on the fire safety and evacuation plan. This has the potential to directly affect the safety of visitors, staff, and all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On July 25, 2024, from 9:30 a.m. to 11:30 a.m., survey staff toured the home with the unlicensed personnel (ULP)-E, survey staff observed the fire evacuation diagrams did not include room numbers for each resident bedroom. Evacuation plans must include the location and resident sleeping room numbers.	0 810			

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0 810	Continued From page 39 On July 25, 2024, at approximately 11:30 a.m. document and record review and interview with the ULP-E, on the home's fire safety and evacuation plan, titled Fire Emergency, dated August 1, 2021, indicated the following: -Document review indicated the licensee's fire safety and evacuation plan did not include the identification of unique or unusual resident needs for movement or evacuation under procedures for resident movement, evacuation, or relocation during a fire or similar emergency. -Document review indicated the licensee's fire safety and evacuation plan did not include and identify in the plan the specific fire protection procedures for residents who are capable of self-evacuation on the proper actions to be taken in case of a fire or similar emergency. During the interview, the ULP-E verified that the fire safety and evacuation plan did not include these provisions. -Record review of available documentation indicated that the licensee did not provide employee training on the fire safety and evacuation plan twice per year after the initial hire training. During an interview, ULP-E stated that they only had conducted drills as part of training. -Record review of the available documentation indicated the licensee failed to provide evacuation training to residents who are capable of self-evacuation on the proper actions to be taken in the case of a fire or similar emergency including movement, evacuation, and relocation at least once per year. The ULP-E was unable to provide documentation showing any training offered to residents on the fire safety and evacuation plan. -Record review indicated the licensee failed to provide the minimum required employee fire evacuation drills twice per year, per shift with at	0 810			

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0 810	Continued From page 40 least one evacuation drill every other month. Record review indicated that a total of one evacuation drill was conducted to date for the year 2024, a total of two drills were conducted for calendar 2023, and four drills were conducted for 2022. During the interview, the ULP-E stated he was not aware of the requirements and had thought the new law requirement for evacuation drills was only every six months or twice a year. The above deficient findings were verified by the ULP-E during the interview. On July 25, 2024, at approximately 11:45 a.m., survey staff explained the above deficient findings to the ULP-E. The ULP-E understood and acknowledged the findings during the exit interview. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810			
0 830 SS=I	144G.45 Subd. 3 Local laws apply Assisted living facilities shall comply with all applicable state and local governing laws, regulations, standards, ordinances, and codes for fire safety, building, and zoning requirements. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to follow applicable state and local laws, regulations, standards, ordinances, and codes related to smoking for one of one resident (R1).	0 830			

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0 830	Continued From page 41 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 the potential to affect a large portion or all of the residents). The findings include: On July 22, 2024, at 9:15 a.m., upon entrance to the facility, the surveyor smelled an odor of smoke. On July 22, 2024, at approximately 10:59 a.m., during a facility tour, the surveyor observed a three-level home that contained three occupied bedrooms and one unoccupied bedroom. The surveyor observed a sign on the outside of R1's bedroom that read, "For safety reasons, please do not smoke in your room. Thank you. Management" The surveyor entered R1's bedroom and observed six cigarette butts and four plastic tips from an unknown smoking source. In addition, R1's floor contained an innumerable amount of burn marks measuring over an area of approximately three feet by three feet. On the outer edges of the area, the burn marks were further apart from each other. Toward the center of the area, the burn marks were concentrated to the point of having the appearance of one large, darkened burn spot. The surveyor could not detect the number of burns marks as the wooden floor was unable to be visualized in between the burn marks. The surveyor inquired with staff to confirm if the marks on the floor were in fact burn marks. Housing	0 830			

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0 830	Continued From page 42 manager/unlicensed personnel (HM/ULP)-A stated R1 was noncompliant with not smoking in their room. HM/ULP-A stated R1 frequently smoked in their room during the overnight hours. HM/ULP-A stated the licensee had talked to R1 related to smoking in the facility however, R1 would become agitated. HM-ULP-A stated they have "warned" R1 on multiple occasions and had documented the occurrences in RTasks (a documenting software program). R1 admitted to the licensee on March 8, 2021, and began receiving assisted living services. R1's diagnoses included anxiety, depression, and schizoaffective disorder (a mental disorder in which a person experiences a combination of symptoms of schizophrenia and mood disorder). R1's service plan signed March 8, 2022, indicated R1 received assistance with medication administration, laundry, housekeeping, daily safety checks, and cues with dressing, oral care, hair care, grooming, and bathing. R1's Residential Lease & Maintenance Agreement signed March 8, 2024, included a section titled Tobacco. The section indicated tobacco was only allowed in the designated areas and tobacco use was prohibited in the common areas, entryways, hallways, and stairwells. R1's Resident Notes - One Resident dated June 1, 2024, through July 23, 2024, contained no progress notes. R1's Service Recap Summary - Month dated July 2024, included the following: - July 1, 2024, R1 was upset when staff addressed them about intentionally smoking in	0 830			

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0 830	Continued From page 43 their room as it has the propensity of causing harm to housemates and staff; - July 3, 2024, R1 continued to become agitated at staff prompts about not smoking in their room; - July 9, 2024, R1 became upset when staff confronted them about smoking in the room; - July 10, 2024, R1 became verbal at staff's multiple prompts about not smoking in their room and to instead go outside. R1 continued to become more and more agitated as they were prompted to the designated smoking area to prevent him from smoking in their room. Staff did not power struggle with him but continued to remind him that smoking in the house is prohibited; - July 11, 2024, R1 became verbally aggressive when staff engaged them about smoking in their room; - July 12, 2024, R1 became verbally aggressive when staff engaged them about smoking in their room as it had the propensity of causing harm to housemates and staff; - July 15, 2024, R1 became verbally upset when staff confronted them about the dangers of smoking in their room; - July 17, 2024, R1 became verbal with staff redirection to the designated smoking areas of the house to prevent him from smoking in the room; - July 19, 2024, R1 became agitated when staff discovered "again" that they had marijuana in their room and were smoking it. Staff informed the guardian; and - July 22, 2024, R1 became verbally aggressive when staff calmly engaged them about smoking in their room. R1's Individual Abuse Prevention Plan Assessment dated March 8, 2022, indicated there were no concerns with safe smoking for R1.	0 830			

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0 830	Continued From page 44 R1's Uniform Assessment Tool Form dated March 8, 2022, indicated R1 smoked traditional cigarettes, R1 had no history of smoking in unapproved areas or damaging property by unsafe smoking, R1 was able to safely use a lighter, R1 handled lit material appropriately, and R1 was independent with smoking. R1's Ongoing Monitoring and Reassessment completed May 26, 2024, indicated there were no changes to R1's service plan or medication. R1's vital signs were stable, R1 had no concerns and seemed like they were in a good mood. On July 23, 2024, at 8:23 a.m., R1 stated they smoked in the backyard and at the bus stop. The surveyor inquired if they ever smoked in their room. R1 stated no. On July 23, 2024, at 2:11 p.m., clinical nurse supervisor (CNS)-C stated R1 smoked one to two packs of cigarettes throughout the day and cigarettes were dispersed to R1 per the guardian's request. CNS-C stated they received calls about R1 smoking in the room and they have had discussions with R1 about smoking in the designated smoking areas. CNS-C stated they did not document any of the conversations they held with R1 related to smoking. The surveyor inquired if they read R1's Service Recap Summary. CNS-C stated, "I try to but not going to lie, sometimes I get busy, but I do my best." The surveyor inquired if any other interventions were placed after R1 was found smoking in their room. CNS-C stated they believed owner/unlicensed personnel (O/ULP)-B spoke to R1's guardian. On July 23, 2024, at 2:24 p.m., the surveyor inquired what interventions were put into place for	0 830			

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0 830	Continued From page 45 R1's smoking within the facility. O/ULP-B stated, "intervention to stop [R1] um honestly would be to just open the window. Of all of guys he is the most challenging, and staff is just trained to redirect him to the designated smoking areas. So, when staff notice him having cigarette going up to room staff are trained to redirect. Please go smoke outside. He complies 70 percent of the time." The surveyor inquired if there were any other interventions for smoking for R1. O/ULP-B stated, "nothing specific that I can tell you that we put in place it is just document and redirect and remind him that smoking in his room is not a safe practice." On July 23, 2024, at 2:59 p.m., O/ULP-B stated the designated smoking area was in the backyard or at the end of the licensee's driveway. The Minnesota Department of Health's Minnesota Clean Indoor Air Act (MCIAA) amendment effective on September 7, 2023, noted smoking was prohibited in health care facilities and clinics. In addition, an indoor area meant a space between a floor and a ceiling that is at least half enclosed by walls, doorways or windows (opened or closed) around the perimeter. A wall included retractable dividers, garage doors, plastic sheeting or any other temporary or permanent physical barrier. Minnesota State Statute 144.414 Prohibitions; Subdivision 3 dated 2023, indicated under a section titled Health care facilities and clinics: (a) Smoking is prohibited in any area of a hospital, health care clinic, doctor's office, licensed residential facility for children, or other health care-related facility, except that a patient or resident in a nursing home, boarding care facility, or licensed residential facility for adults may	0 830			

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0 830	Continued From page 46 smoke in a designated separate, enclosed room maintained in accordance with applicable state and federal laws. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	0 830			
0 910 SS=C	144G.50 Subd. 2 (a-b) Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name and the health facility identification of the facility. (b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for all residents who resided in the licensee's facility. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents).	0 910			

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0 910	Continued From page 47 The findings include: The licensee's Assisted Living Contract for Housing and Services lacked the following required content: - in a conspicuous place and manner on the contract the Health Facility Identification number (HFID#) of the facility. On July 24, 2024, at 8:52 a.m., owner/unlicensed personnel (O/ULP)-B stated the blank contract was used for all residents who resided at the licensee's assisted living facility. O/ULP-B verified the blank contract did not include the licensee's HFID#. O/ULP-B stated they thought the contract only required the licensee's assisted living license number. O/ULP-B stated they hired a consultant to provide the licensee with paper documents and the consultant provided the licensee a contract that only required the assisted living licensure number. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 910			
01290 SS=G	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	01290			

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01290	Continued From page 48 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 observation, interview, and record review, the licensee failed to ensure a background study clearance was submitted and received in affiliation with the assisted living license for one of eight employees (unlicensed personnel (ULP)-E). 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 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 finding include: ULP-E was hired on March 1, 2021, to provide direct care services to residents. The licensee's Staff Shift 2024, indicated ULP-E was the only employee working on Sunday July 21, 2024, from 7:00 p.m., to 7:00 a.m. On July 23, 2024, at 9:48 a.m., the surveyor observed the licensee's Minnesota Department of Human Services NETStudy 2.0 (a web-based system used to submit background study	01290			

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NAME OF PROVIDER OR SUPPLIER DIVINE HOME CARE SERVICES LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3307 O'HENRY ROAD BROOKLYN CENTER, MN 55429		
(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
01290	Continued From page 49 requests) roster for health facility identification number (HFID#) 36163 and observed ULP-E was "Eligible - COVID-19 Study - Expired" with an expiration date of December 31, 2022. ULP-E lacked a valid background study affiliated with HFID# 36163. On July 23, 2024, at 10:23 a.m., owner/unlicensed personnel (O/ULP)-B stated ULP-E completed their background study in 2021 and at the time background studies did not require fingerprints for ULP-E. O/ULP-B stated they did not complete a new background study on ULP-E after December 31, 2022. O/ULP-E stated there were not aware they needed to complete a new background study and believed once a background study was completed it would not have to be completed again. On July 23, 2024, the Minnesota Department of Human Services website indicated the following: Emergency studies completed during the COVID-19 pandemic were no longer valid. Individuals who only had an emergency study must have a fully compliant, fingerprint-based background study. Roster maintenance - Individuals with a completed emergency study will remain on the entity's roster unless the entity removes the individual. Entities should remove individuals with emergency studies that are no longer affiliated; - If the individual should no longer be affiliated and has a new fully compliant background study, the entity should wait until the individual is separated and then remove both the emergency study and fully compliant study from their roster at the same time; - All entities are responsible for maintaining their rosters regularly and removing study subjects	01290			

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01290	Continued From page 50 from their roster when they are no longer affiliated; and - Entities are responsible for identifying who needs to submit a new background study. For help identifying which study subjects still have an emergency study and need a fully compliant study, entities should refer to the instructional guide, "Identifying Emergency Studies" in the help section of NETStudy 2.0. The licensee's undated Employee Records policy, indicated the employee record would include "Documentation of background study and fingerprints as required by section 144A.057." The policy did not address requirements under the assisted living statutes. No further information provided. TIME PERIOD FOR CORRECTION: Immediate	01290			
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;	01370			

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01370	Continued From page 51 (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 (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 evaluations were completed for all required skill areas, prior to providing services, for one of three unlicensed personnel (housing manager/unlicensed personnel (HM/ULP)-A). 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	01370			

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01370	Continued From page 52 failure that has affected or has potential to affect a large portion or all of the residents). The findings include: HM/ULP-A HM/ULP-A was hired on March 28, 2024, to oversee day to day operations of the facility and to provide direct care services to residents. On July 23, 2024, at 8:23 a.m., the surveyor observed HM/ULP-A administer oral medications to R1. HM/ULP-A's record lacked the following required content: - training: - appropriate and safe techniques in person hygiene and grooming that included hair care and bathing, care of teeth and oral prosthetic devices, care and use of hearing aids, and toileting; - stand by assistance techniques and how to perform them; - communication skills that include preserving the dignity of the residents and showing respect for the resident and the residents preferences, cultural background, and family; - maintenance of a clean and safe environment; - understanding appropriate boundaries between staff and residents and the residents family; and - awareness of commonly used health technology equipment and assistive devices. - competency evaluations: - appropriate and safe techniques in person hygiene and grooming that included hair care and bathing, care of teeth and oral prosthetic devices, care and use of hearing aids, and toileting; and - stand by assistance techniques and how to	01370			

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01370	Continued From page 53 perform them. On July 24, 2024, at 9:36 a.m., owner/unlicensed personnel (O/ULP)-B stated they and their spouse (ULP-E) received training from a consultant. O/ULP-B stated the other ULP who worked at the facility received trainings by watching You Tube videos and ULP completed competency evaluations on paper. The surveyor listed the topics above and inquired if other ULP received the training and competency evaluations listed above. O/ULP-B stated the licensee tailored their training program to the needs of the residents they served and currently the residents who resided in the facility did not need the cares listed above. O/ULP-B stated if there was a change of condition with the residents the licensee served, the licensee would add in the training and competency evaluations listed above. O/ULP-B stated they were not aware of the requirements and their consultant did not inform them that the items listed above needed to be completed for all ULP that did not have a certified nursing assistant certificate. On July 24, 2024, at 10:49 a.m., clinical nurse supervisor (CNS)-C stated they believed hair care was part of the training. CNS-C stated they were unsure if they trained ULP on oral care because residents were independent in this task. CNS-C stated they did not train on toileting, transfers, ambulation, and range of motion. CNS-C stated if there was a resident in the facility who required the skill, they would train on the topic. The licensee's undated staff competency read, "Home Health Aides (HHA) providing comprehensive home care services and who have not completed a state-approved formal training and competency evaluation program will	01370			

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01370	Continued From page 54 demonstrate competency through the following process - Satisfactory completion of an oral or written test on the tasks the HHA will perform. Home Health Aides may not work for Divine Home Care Services until they have successfully passed the written and demonstration competency evaluation. Satisfactory completion of the following - Observation, reporting and documenting of client status - Basic knowledge of body functioning and changes in body function, injuries, or other reportable changes - Recognizing physical, emotional, cognitive and development needs of the client - Basic infection control, including blood-borne pathogens - Maintenance of a clean and safe environment - Falls prevention - Safe transfer techniques and ambulation - Range of motion and positioning - Medication, exercise, and treatment reminders - Basic nutrition, meal preparation, food safety and assistance with eating - Preparation of modified diets - Communication skills and barriers - Cultural diversity - Confidentiality/privacy - Professional boundaries - Handling of emergencies - Commonly used technology equipment and assistive devices the following topics must be completed by a practical skill test - Appropriate and safe techniques in personal hygiene and grooming, including bathing, hair care, oral hygiene (teeth, gums, and oral	01370			

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01370	Continued From page 55 prosthetics), care and use of hearing aids, dressing and toileting - Safe transfer techniques and ambulation - Range of motion and positioning - Reading and recording temperature, pulse, and respirations - Administration of medications and treatments, as required - Other delegated tasks" No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370			
01380 SS=F	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	01380			

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01380	Continued From page 56 review, the licensee failed to ensure training and competency evaluations were completed for all required skill areas, prior to providing services, for one of three unlicensed personnel (unlicensed personnel/housing manager (ULP/HM)-A). 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: HM/ULP-A was hired on March 28, 2024, to oversee day to day operations of the facility and to provide direct care services to residents. On July 23, 2024, at 8:23 a.m., the surveyor observed HM/ULP-A administer oral medications to R1. HM/ULP-A's record lacked the following required content: - training: - basic knowledge of body functioning and changes in body functioning, injuries, or other observed changed that must be reported to appropriate personnel; - recognizing physical, emotional, cognitive, and developmental needs of the resident; - safe transfers and ambulation; and - range of motioning and positioning. - competency evaluations: - safe transfers and ambulation; and - range of motioning and positioning.	01380			

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01380	Continued From page 57 On July 24, 2024, at 9:36 a.m., owner/unlicensed personnel (O/ULP)-B stated they and their spouse (ULP-E) and themselves received training from a consultant. O/ULP-B stated the other ULP who worked at the facility received trainings by watching You Tube videos and ULP completed competency evaluations on paper. The surveyor listed the topics above and inquired if other ULP received the training and competency evaluations listed above. O/ULP-B stated the licensee tailored their training program to the needs of the residents they served and currently the residents who resided in the facility did not need the cares listed above. O/ULP-B stated if there was a change of condition with the residents the licensee served, the licensee would add in the training and competency evaluations listed above. O/ULP-B stated they were not aware of the requirements and their consultant did not inform them that the items listed above needed to be completed for all ULP that did not have a certified nursing assistant certificate. On July 24, 2024, at 10:49 a.m., clinical nurse supervisor (CNS)-C stated they did not train on toileting, transfers, ambulation, and range of motion. CNS-C stated if there was a resident in the facility who required the skill, they would train on the topic. The licensee's undated staff competency read, "Home Health Aides (HHA) providing comprehensive home care services and who have not completed a state-approved formal training and competency evaluation program will demonstrate competency through the following process - Satisfactory completion of an oral or written test on the tasks the HHA will perform. Home	01380			

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01380	Continued From page 58 Health Aides may not work for Divine Home Care Services until they have successfully passed the written and demonstration competency evaluation. Satisfactory completion of the following - Observation, reporting and documenting of client status - Basic knowledge of body functioning and changes in body function, injuries, or other reportable changes - Recognizing physical, emotional, cognitive and development needs of the client - Basic infection control, including blood-borne pathogens - Maintenance of a clean and safe environment - Falls prevention - Safe transfer techniques and ambulation - Range of motion and positioning - Medication, exercise, and treatment reminders - Basic nutrition, meal preparation, food safety and assistance with eating - Preparation of modified diets - Communication skills and barriers - Cultural diversity - Confidentiality/privacy - Professional boundaries - Handling of emergencies - Commonly used technology equipment and assistive devices the following topics must be completed by a practical skill test - Appropriate and safe techniques in personal hygiene and grooming, including bathing, hair care, oral hygiene (teeth, gums, and oral prosthetics), care and use of hearing aids, dressing and toileting - Safe transfer techniques and ambulation - Range of motion and positioning	01380			

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01380	Continued From page 59 - Reading and recording temperature, pulse, and respirations - Administration of medications and treatments, as required - Other delegated tasks" No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380			
01500 SS=F	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	01500			

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01500	Continued From page 60 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 employees received at least eight (8) hours of training for each 12 months of employment for two of two employees (owner/unlicensed personnel (O/ULP)-B, unlicensed personnel (ULP)-E). This practice resulted in a level two violation (a	01500			

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01500	Continued From page 61 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: The licensee's employee list showed one other employee besides O/ULP-B and ULP-E hired prior to 2023. O/ULP-B O/ULP-B opened the licensee's company in 2018. O/ULP-B began providing assisted living services on August 1, 2021. O/ULP-B oversaw the licensee's operations and provided direct care services to residents. ULP-E ULP-E was hired on March 1, 2021, to oversee the licensee's operations and provided direct care services to residents. O/ULP-B and ULP-E's employee records included training from 2021. O/ULP-B and ULP-E's employee record lacked training after 2021. On July 24, 2024, at 9:31 a.m., O/ULP-B verified O/ULP-B and ULP-E's record lacked required annual training. O/ULP-B stated they may need to hire a consultant to assist them. The licensee's Staff Orientation & Education policy indicated all direct care home care [assisted living] staff would complete at least eight hours of education for every 12 months of employment.	01500			

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01500	Continued From page 62 No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500			
01530 SS=F	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the	01530			

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01530	Continued From page 63 licensee failed to ensure direct-care staff received at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date for one of one direct care employee (housing manager/unlicensed personnel (HM/ULP)-A). 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: HM/ULP-A was hired on March 28, 2024, to oversee day to day operations of the facility and to provide direct care services to residents. HM/ULP-A's employee record had no dementia care training. HM/ULP-A lacked eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. On July 24, 2024, at 9:24 a.m., O/ULP-B stated they do not provide dementia care training for any of the staff members because none of the licensee's residents have dementia or have symptoms of dementia. O/ULP-B stated they customize their trainings to the medical diagnoses and physical needs of the residents. O/ULP-B stated the licensee was open to providing dementia care training for all employees when they received a resident with dementia. The surveyor reviewed the regulation related to dementia care training with O/ULP-B. O/ULP-B	01530			

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01530	Continued From page 64 stated they were unaware of the regulation. The licensee's undated Staff Orientation & Education policy did not meet the current statute requirements related to dementia care training. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530			
01620 SS=D	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 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.	01620			

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01620	Continued From page 65 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) completed a smoking assessment when changes occurred 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). The findings include: R1 admitted to the licensee on March 8, 2021, and began receiving assisted living services. R1's diagnoses included anxiety, depression, and schizoaffective disorder (a mental disorder in which a person experiences a combination of symptoms of schizophrenia and mood disorder). R1's service plan signed March 8, 2022, indicated R1 received assistance with medication administration, laundry, housekeeping, daily safety checks, and cues with dressing, oral care, hair care, grooming, and bathing. On July 22, 2024, at 9:15 a.m., upon entrance to the facility, the surveyor smelled an odor of cigarette smoke. On July 22, 2024, at 10:59 a.m., during a facility tour, the surveyor observed a three-level home	01620			

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01620	Continued From page 66 that contained three occupied bedrooms and one unoccupied bedroom. The surveyor observed a sign on the outside of R1's bedroom that read, "For safety reasons, please do not smoke in your room. Thank you. Management" The surveyor entered R1's bedroom and observed six cigarette butts and four plastic tips from an unknown smoking source. In addition, R1's floor contained an innumerable amount of burn marks measuring over an area of approximately three feet by three feet. On the outer edges of the area, the burn marks were further apart from each other. Toward the center of the area, the burn marks were concentrated to the point of having the appearance of one large, darkened burn spot. The surveyor could not detect the number of burns marks as the wooden floor was unable to be visualized in between the burn marks. The surveyor inquired with staff to confirm if the marks on the floor were in fact burn marks. Housing manager/unlicensed personnel (HM/ULP)-A stated R1 was noncompliant with not smoking in their room. HM/ULP-A stated R1 frequently smoked in their room during the overnight hours. HM/ULP-A stated the licensee had talked to R1 related to smoking in the facility however, R1 would become agitated. HM-ULP-A stated they have "warned" R1 on multiple occasions and had documented the occurrences in RTasks (a documenting software program). R1's Service Recap Summary - Month dated July 2024, included the following: - July 1, 2024, R1 was upset when staff addressed them about intentionally smoking in their room as it has the propensity of causing harm to housemates and staff; - July 3, 2024, R1 continued to become agitated at staff prompts about not smoking in their room; - July 9, 2024, R1 became upset when staff	01620			

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01620	Continued From page 67 confronted them about smoking in the room; - July 10, 2024, R1 became verbal at staff's multiple prompts about not smoking in their room and to instead go outside. R1 continued to become more and more agitated as they were prompted to the designated smoking area to prevent him from smoking in their room. Staff did not power struggle with him but continued to remind him that smoking in the house is prohibited; - July 11, 2024, R1 became verbally aggressive when staff engaged them about smoking in their room; - July 12, 2024, R1 became verbally aggressive when staff engaged them about smoking in their room as it had the propensity of causing harm to housemates and staff; - July 15, 2024, R1 became verbally upset when staff confronted them about the dangers of smoking in their room; - July 17, 2024, R1 became verbal with staff redirection to the designated smoking areas of the house to prevent him from smoking in the room; - July 19, 2024, R1 became agitated when staff discovered "again" that they had marijuana in their room and were smoking it. Staff informed the guardian; and - July 22, 2024, R1 became verbally aggressive when staff calmy engaged them about smoking in their room. R1's Individual Abuse Prevention Plan Assessment dated March 8, 2022, indicated there were no concerns with safe smoking for R1. R1's ongoing assessment dated March 8, 2022, included the following information related to smoking: R1 smoked traditional cigarettes, R1 had not been offered resources to assist with	01620			

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01620	Continued From page 68 smoking cessation, R1 had no history of smoking in unapproved areas, R1 had no history of damaging property or others by smoking unsafely, R1 understood designated smoking areas, R1 was able to handle smoking material appropriately, and R1 was independent with smoking. R1's ongoing assessment dated February 26, 2024, included the following information: R1's assessment was completed in person, no changes, R1's vital signs were stable, no complaints of pain, no other concerns, R1 was prescribed glasses, and R1 was in a good mood. In addition, no changes were needed to the service plan. R1's assessment lacked an updated smoking assessment. R1's ongoing assessment dated May 26, 2024, included the following information: R1's assessment was completed in person, no changes were made to the service plan, no changes to medication, R1's vital signs were stable, R1 had no concerns, and R1 was in a good mood. R1's assessment lacked an updated smoking assessment. On July 24, 2024, at 10:58 a.m., clinical nurse supervisor (CNS)-C stated all resident ongoing assessments were completed using the one page form the surveyor observed in R1's record. CNS-C stated they reviewed the initial assessment which utilized the uniform assessment tool and compared their in person assessment to the form. If there were no changes to the resident they would indicate no change. The surveyor inquired why R1's smoking assessment was not updated with a change. CNS-C stated, "I think it was an oversight. We did not know we needed to update that."	01620			

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01620	Continued From page 69 The licensee's undated Assessment - Comprehensive Services indicated all new clients [residents] shall have an individualized assessment completed by the RN to develop a personalized service plan and the assessment shall be revised regularly and as appropriate. In addition, the RN would conduct a comprehensive assessment to include: - client [resident] evaluation; - vulnerability assessment; - medication profile; - home health aide care plan; - emergency information; - falls risk assessment (if appropriate); - mental status assessment (if appropriate); - home safety checklist (if appropriate); and - medication management plan (if appropriate). The licensee's policy did not meet the statutory requirements. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) day	01620			
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;	01650			

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01650	Continued From page 70 (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 the service plan included all required content for three of three residents (R1, R2, 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 the potential to affect a large portion or all of the residents). The findings include: R1	01650			

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01650	Continued From page 71 R1 admitted to the licensee on March 8, 2021, and began receiving assisted living services. R1's service plan signed March 8, 2022, indicated R1 received assistance with mediation administration, laundry, housekeeping, daily safety checks, and cues with dressing, oral care, hair care, grooming, and bathing. R2 R2 admitted to the licensee on November 10, 2022, and began receiving assisted living services. R2's service plan signed November 10, 2022, indicated R2 received assistance with mediation administration, laundry, housekeeping, assistance with bathing, daily safety checks, and cues with dressing, oral care, hair care, and grooming. R3 R3 admitted to the licensee on November 1, 2022, and began receiving assisted living services. R3's service plan signed November 1, 2021, indicated R3 received assistance with mediation administration, laundry, housekeeping, daily safety checks, and cues with dressing, oral care, hair care, grooming, and bathing. R2, R3, and R5's service plan lacked the following content: - schedule of monitoring assessments of a resident. On July 24, 2024, at 8:57 a.m., owner/unlicensed personnel (O/ULP)-B stated they purchased the service plan template from a consultant and	01650			

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01650	Continued From page 72 believed it had all of the required information on it. The licensee's undated Service Plan policy indicated the service plan would include the schedule and methods of monitoring reviews or assessments of the client [resident]. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650			
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to accurately document medications administered for one of two residents (R1). This practice resulted in a level two violation (a	01760			

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01760	Continued From page 73 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 admitted to the licensee on March 8, 2021, and began receiving assisted living services. R1's diagnoses included anxiety, depression, and schizoaffective disorder (a mental disorder in which a person experiences a combination of symptoms of schizophrenia and mood disorder). R1's service plan signed March 8, 2022, indicated R1 received assistance with medication administration, laundry, housekeeping, daily safety checks, and cues with dressing, oral care, hair care, grooming, and bathing. On July 23, 2024, at 8:23 a.m., the surveyor observed HM/ULP-A remove a trazodone 300 milligram (mg) tablet into the medication cup. HM/ULP-A stated, "sorry I am giving bedtime." HM/ULP-A placed the medication back into the blister pack and sealed with tape. The surveyor observed HM/ULP-A remove topiramate 100 mg, propranolol 20 mg, and vitamin E 1000 units (U) and place into the medication cup. HM/ULP-A signed each blister card after the medication was placed into the medication cup, went to the kitchen with medication cup, handed the medication cup to R1, and R1 consumed the medication. HM/ULP-A then walked back to the office, opened RTasks (a documenting software	01760			

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01760	Continued From page 74 program), marked verify and administered on clozapine 50 mg, propranolol 20 mg, topiramate 100 mg, and vitamin E 1000 u, and then marked complete at the bottom. The surveyor did not observe clozapine 50 mg being administered to R1. The surveyor inquired why they signed for a medication that was not administered. HM/ULP-A stated they forgot. Owner/unlicensed personnel (O/ULP)-B stated clarification was needed with pharmacy on the clozapine order because they were only sending the licensee the evening dose. On July 23, 2024, at 11:53 a.m., HM/ULP-A stated they followed the prescription label for what medications to administer. The surveyor inquired how they were trained for medication administration. HM/ULP-A stated they were trained to look at the electronic medication administration record (EMAR) and compare it to the prescription label. HM/ULP-A stated, "I verify going forward I am going to do that." On July 24, 2024, at 10:26 a.m., HM/ULP-A stated they watched a You Tube video, completed in person training, and completed a return demonstration to their supervisor on medication administration and documentation. On July 24, 2024, at 11:07 a.m., clinical nurse supervisor (CNS)-C stated ULP were trained to use the five rights of medication administration. CNS-C stated ULP were trained to compare the prescription label to the EMAR because the prescription label may not be correct. CNS-C stated ULP were trained to document on a medication after the medications were administered because if the resident refused the medication, it would be "falsifying" medication documentation.	01760			

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01760	Continued From page 75 The licensee's undated Medication documentation policy indicated all medication administered by the licensee's staff would be documented in the client's [resident's] record and documentation would be factual, complete, and legible. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760			
01890 SS=E	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to discard expired medication for two of three residents (R2, 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).	01890			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36163	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/25/2024
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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
01890	Continued From page 76 The findings include: On July 22, 2024, at 9:59 a.m., during the entrance conference, clinical nurse supervisor (CNS)-C stated they reviewed the medication cabinet for expired medications each time they were at the facility. CNS-C stated typically they remove the prescription label, placed the medication in water, and then threw the medication away. On July 22, 2024, at approximately 10:59 a.m., during a facility tour, the surveyor observed the medication cabinet and observed the following expired medications: -R2: nicotine 4 milligram (mg) gum with an expiration date of December 9, 2022, Aspercream lidocaine 4 percent (%) with an expiration date of August 2023, clotrimazole 1 % cream with an expiration date of December 7, 2023; and -R3: Alphagan 0.1 % with an expiration date of January 19, 2024. On July 24, 2024, at 11:10 a.m., CNS-C stated they destroyed expired medications each time they were at the facility and "I do my due diligence to look into the cabinet." The licensee's Disposition/Disposal of Medications dated 2011 indicated discontinued or expired medication would be disposed of in accordance with the instructions proved on the drug label or by the licensee's policy by a licensed nurse. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890			

Minnesota Department of Health

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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 provide documentation in the resident's record regarding the disposition of medication to include medication's name, strength, prescription number as applicable, quantity, date of disposition, to whom the medications were given, and names of staff and other individuals involved in the disposition. 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			

Minnesota Department of Health

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01910	Continued From page 78 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: On July 22, 2024, at 9:59 a.m., during the entrance conference, owner/unlicensed personnel (O/ULP)-B stated if a medication was discontinued or expired, they would mark out sensitive information on the prescription label and place the medication in the garbage. O/ULP-B stated, "I will be honest. We do not document disposition of medications." Clinical nurse supervisor (CNS)-C stated they reviewed the medication cabinet for expired medications each time they were at the facility. CNS-C stated typically they removed the prescription label, placed the medication in water, and then threw the medication away. CNS-C stated they did not document on medication disposal however, if documentation was required, they would start to document the medications they disposed of. The licensee's Disposition/Disposal of Medications dated 2011 indicated the licensee would document the following information in the resident record upon disposition of a medication: - name, strength, and prescription number of medications, as applicable; - quantity; - method of disposition or to whom the medications were given; - date of disposition; and - name (s)/signature (s) of staff involved in the disposition. No further information was provided.	01910			

Minnesota Department of Health

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01910	Continued From page 79	01910			
	TIME PERIOD FOR CORRECTION: Seven (7) days				
02320 SS=D	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure unlicensed personnel (housing manager/unlicensed personnel (HM/ULP)-A) followed appropriate medication administration procedures. 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: HM/ULP-A was hired on March 28, 2024, to oversee day to day operations of the facility and to provide direct care services to residents. HM/ULP-A's employee record included an	02320			

Minnesota Department of Health

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02320	Continued From page 80 unsigned undated medication training. HM/ULP-A's employee file lacked a documented medication competency evaluation. On July 23, 2024, at 8:23 a.m., the surveyor observed HM/ULP-A remove a trazodone 300 milligram (mg) tablet into the medication cup. HM/ULP-A stated, "sorry I am giving bedtime." HM/ULP-A placed the medication back into the blister pack and sealed with tape. The surveyor observed HM/ULP-A remove topiramate 100 mg, propranolol 20 mg, and vitamin E 1000 units (U) and place into the medication cup. HM/ULP-A signed each blister card after the medication was placed into the medication cup, went to the kitchen with medication cup, handed the medication cup to R1, and R1 consumed the medication. HM/ULP-A then walked back to the office, opened RTasks (a documenting software program), marked verify and administered on clozapine 50 mg, propranolol 20 mg, topiramate 100 mg, and vitamin E 1000 u, and then marked complete at the bottom. The surveyor did not observe clozapine 50 mg being administered to R1. The surveyor inquired why they signed for a medication that was not administered. HM/ULP-A stated they forgot. Owner/unlicensed personnel (O/ULP)-B stated clarification was needed with pharmacy on the clozapine order because they were only sending the licensee the evening dose. On July 23, 2024, at 11:53 a.m., HM/ULP-A stated they followed the prescription label for what medications to administer. The surveyor inquired how they were trained for medication administration. HM/ULP-A stated they were trained to look at the electronic medication administration record (EMAR) and compare it to the prescription label. HM/ULP-A stated, "I verify going forward I am going to do that."	02320			

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02320	Continued From page 81 On July 24, 2024, at 10:26 a.m., HM/ULP-A stated they watched a You Tube video, completed in person training, and completed a return demonstration to their supervisor on medication administration. In addition, HM/ULP-A stated they received a 30-day supervision related to medication administration. On July 24, 2024, at 11:07 a.m., clinical nurse supervisor (CNS)-C stated ULP were trained to use the five rights of medication administration. CNS-C stated ULP were trained to compare the prescription label to the MAR because the prescription label may not be correct. The licensee's undated Medication Administration policy indicated ULP have passed a competency evaluation to all medication routes prior to administering medication. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320			

Type: Full
Date: 07/22/24
Time: 14:05:41
Report: 8058241163

Food and Beverage Establishment Inspection Report

Page 1

Location:

Divine Home Care Services Llc
Divine Home Care Services LLC
3307 O'Henry Road
Brooklyn Center, MN55429
Hennepin County, 27

Establishment Info:

ID #: 0038500
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6127032986
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.

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

Hot Water: = at 160 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: PANCAKE
Temperature: 41 Degrees Fahrenheit - Location: COOLER
Violation Issued: No

Process/Item: CRAB
Temperature: 41 Degrees Fahrenheit - Location: COOLER
Violation Issued: No

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

HRD INSPECTOR: ASHLEY CREWS

RESIDENTIAL KITCHEN WITH NON COMMERCIAL APPLIANCES

Type: Full
Date: 07/22/24
Time: 14:05:41
Report: 8058241163
Divine Home Care Services Llc

Food and Beverage Establishment Inspection Report

Page 2

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 8058241163 of 07/22/24.

Certified Food Protection Manager: ASSATA SHERIFF

Certification Number: 108683 Expires: 11/26/24

Inspection report reviewed with person in charge and emailed.

Signed: _____
Establishment Representative

Signed:  _____
Aaron Gertz
Sanitarian 3
MDH Metro Office
651 201 4500
health.foodlodging@state.mn.us