Electronically Delivered

March 29, 2023

Licensee
Elder Homestead
11400 4th Street North
Minnetonka, MN 55343

RE: Project Number(s) SL20104015

Dear Licensee:

The Minnesota Department of Health completed an evaluation on March 8, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines and enforcement actions based on the level and scope of the violations; **however, no immediate fines are assessed for this evaluation of your facility**.

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up evaluations. The licensee is not required to submit a plan of correction for approval.

The correction order documentation should include the following:

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

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

correction order receipt date.

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

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

Please address your cover letter for reconsideration requests to:

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

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,

Jess Schoenecker, Supervisor
State Evaluation Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: Jess.Schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 651-281-9796

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20104	A. BUILDING: _____ B. WING _____	03/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELDER HOMESTEAD	11400 4TH STREET NORTH MINNETONKA, MN 55343

(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: SL20104015 On March 7, 2023, through March 8, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were forty-three (43) active residents receiving services under the Assisted Living/ Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 650 SS=F	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled	0 650		

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0 650	Continued From page 1 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 the employee record contained the required content for two of two employees (registered nurse (RN)-A, unlicensed personnel (ULP)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	0 650		

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0 650	Continued From page 2 The findings include: RN-A had a hire date of April 5, 2017. RN-A's record lacked the following: - records of orientation, required annual training and infection control training, and competency evaluations; - current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; - documentation of annual performance reviews that identify areas of improvement needed and training needs; - for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and - documentation of the background study as required under section 144.057. ULP-B had a hire date of October 23, 2018. ULP-B's record lacked the following: - records of orientation, required annual training and infection control training, and competency evaluations; - current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; -documentation of annual performance reviews that identify areas of improvement needed and training needs; - for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and During entrance conference on March 7, 2023, at 10:10 a.m., RN-A and licensed assisted living	0 650		

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0 650	Continued From page 3 director (LALD)-C stated they were aware of what was required in the employee record. During interview on March 7, 2023, at 10:15 a.m., LALD-C stated he would need to contact human resources to get the needed information for RN-A and ULP-B. LALD-C stated he would get back to surveyor with the requested documentation. During interview on March 7, 2023, at 10:30 a.m., RN-A stated she thought she had the required health screening and stated that she did know she did not have any annual performance reviews completed. At the time of exit on March 8, 2023, at 11:00 a.m., LALD-C was not able to provide the requested documentation for RN-A or ULP-B. LALD-C stated RN-A did not have any annual performance reviews completed and was not sure where RN-A's or ULP-B's documentation of orientation, health screenings, annual performance reviews, or infection control training. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity	0 660		

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0 660	Continued From page 4 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 establish and maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included completion of a TB facility risk assessment as well as the completion of a two-step TST (tuberculin skin test) or other evidence of TB screening such as a blood test for two of two employees (registered nurse (RN)-A, licensed practical nurse (LPN)-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a 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 lacked a TB risk assessment. RN-A had a hire date of April 5, 2017. RN-A provided direct care to residents of the assisted	0 660		

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0 660	Continued From page 5 living. RN-A's employee record lacked documentation a completed TST. LPN-D had a hire date of July 25, 2011. LPN-D provided direct care to residents of the assisted living. LPN-D's employee record indicated they had received one of a two-step TST completed on February 19, 2023. There was no record in LPN-D's employee record indicating she had received any other TST. During an interview on March 8, 2023, at 2:30 p.m., licensed assisted living director (LALD)-C was asked if RN-A or LPN-D had any other TST documentation in their employee records. LALD-C stated he would speak with human resources to see if there was any other documentation available. The Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July 2013, noted baseline screening for all health care workers (HCW) included a history and symptom screen, and testing for the presence of TB infection. The regulations noted a blood test should include the date of the test. The licensee's undated TB Exposure Control Plan indicated a facility risk assessment would be conducted annually or more often if indicated. The policy also stated HCW would have a pre-placement and annual TB skin test. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		

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0 780	Continued From page 6	0 780		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in 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 smoke alarms that are interconnected so that actuation of one alarm causes all alarms in the dwelling unit to actuate. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 780		

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0 780	Continued From page 7 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: On March 8, 2023, at approximately 10:00 a.m., survey staff toured the facility with the Interim Resident Director (LALD)-C and the Maintenance Supervisor (MD)-G. During the facility tour, survey staff observed that in the in-parlor suite A, parlor suite B and parlor suite C on the second floor, the sleeping rooms that were equipped with smoke alarms were not interconnected with the other smoke alarms in the dwelling unit, so the actuation of one alarm would cause all alarms to operate. It was also observed that the resident unit doors were Dutch doors with no fire rating information. During the interview, LALD-C stated that the Dutch doors were not the fire- rated doors, and each parlor suite was one dwelling unit. This deficient condition was visually verified by LALD-C accompanying the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
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	0 800		

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0 800	Continued From page 8 good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents. This deficient condition had the ability to affect a limited number of staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On March 8, 2023, at approximately 10:00 a.m., survey staff toured the facility with the Interim Resident Director (LALD)-C and the Maintenance Supervisor (MD)-G. During the facility tour, survey staff observed the following items: In Resident units 205, 204, and 203, it was observed that door closers on the resident doors had been disabled by removing the closure arm or closure device. The doors had a portion or remnants of the closure device still mounted on	0 800		

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0 800	Continued From page 9 the door. MD-G stated that this was consistent with many other resident units throughout the facility. The door closure device is required to make the door close and positively latch to maintain the fire integrity of the resident room and corridor for safety purposes. Elevator lobby door on the second floor, it was observed that the fire-rated door with magnetic hold open did not close or positively latch when the magenta was released from the open position. Door magnets release the door from the open position in the event of a fire, and the door must positively latch to protect the occupants and to contain the spread of fire. In the large dining room on the first floor, it was observed that the door hardware at door head was broken and prevented the door from closing. In the memory care dining room on the second floor, it was observed that the fire-rated dining room door with a magnetic hold open did not close or positively latch when the magnet was released from the open position. Door magnets release the door from the open position in the event of a fire and the door must positively latch to protect the occupants and to contain the spread of fire. MD-G visually verified this deficient finding at the time of discovery. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment	0 810		

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0 810	Continued From page 10 (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop a fire safety and evacuation plan with required elements; failed to provide required employee training on	0 810		

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0 810	Continued From page 11 fire safety and evacuation; failed to provide training to residents capable of assisting in their own evacuation and failed to conduct required evacuation drills. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: An interview and record review of the available documentation were conducted on March 8, 2023, at approximately 10:00 a.m. with the Interim Resident Director (LALD)-C and the Maintenance Supervisor (MD)-G on the fire safety and evacuation plan, fire safety and evacuation training for the facility, and fire safety and evacuation drills for the facility. Record review of the available documentation indicated that the licensee did not have fire protection procedures necessary for residents included in the fire safety and evacuation plan. During the interview, LALD-C verified that the fire safety and evacuation plan lacked these provisions. Record review of the available documentation indicated that employees did not receive training twice per year after initial hire. During the interview, LALD-C stated that the licensee provided annual training to employees, but not	0 810		

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0 810	Continued From page 12 twice per year after the initial hire, on the fire safety and evacuation plan, as required by statute. During the interview, LALD-C verified this deficient condition and confirmed that there was no further documented training for the staff on the fire safety and evacuation plan as required by statute. With a further review of the Emergency Disaster Plan provided by LALD-C, it was observed that the Emergency Disaster Plan did not include any employee training requirements on fire safety and evacuation plan. Record review of the available documentation did not indicate that the licensee provides annual training to residents who can assist in their own evacuation on the proper actions to take in the event of a fire to including movement, evacuation, or relocation as required by statute. Record review of the available documentation indicated that the licensee did not conduct evacuation drills twice per year per shift and every other month as required by statute. Review of the Emergency Disaster Plan provided by LALD-C indicated that fire drills are to be conducted 2 times per year, not every other month as required by statute. Review of the provided documented drills indicated that the licensee had conducted fire drills on 3/22, 5/22,8/30, and 9/22 only. With further review, it was observed that the licensee failed to provide two drills on the second shift and the third shift. LALD-C verified that there were no further drills conducted besides those that were provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		

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	20104	A. BUILDING: _____ B. WING _____	03/08/2023

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01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days.	01060		

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01060	Continued From page 14 (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to notify the Office of Ombudsman for Long-Term Care (OOLTC) of resident relocation within four days for two of two residents (R5, R6). 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 Resident Roster dated February 27, 2023, identified R5's date of admission was June 1, 2022, and date of emergency transfer to a local hospital for evaluation was January 10, 2023. R5 did not return to licensee from the hospital. R5's designated representative was notified at the time of emergency transfer to the hospital. The licensee's Resident Roster dated February 27, 2023, identified R6's date of admission was September 30, 2019, and date of emergency transfer to a local hospital for evaluation was December 22, 2022. R6 did not return to	01060		

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01060	Continued From page 15 licensee from the hospital. R6's designated representative was notified at the time of emergency transfer to the hospital. During interview on March 8, 2023, at approximately 10:15 a.m., licensed assisted living director (LALD)-C and registered nurse (RN)-A stated they were not aware that the Regional Ombudsman needed to be notified when a resident was out of the establishment for more than four days. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
01470 SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person;	01470		

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01470	Continued From page 16 (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and 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	01470		

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01470	Continued From page 17 orientation to include all required content for three of three employees (registered nurse (RN)-A, unlicensed personnel (ULP)-B, licensed practical nurse (LPN)-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a 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: RN-A was hired on April 5, 2017, to provide direct care services to licensee's assisted living residents. ULP-B was hired on October 23, 2018, to provide direct care services to licensee's assisted living residents. LPN-D was hired on July 25, 2011, to provide direct care services to licensee's assisted living residents. RN-A, ULP-B, and LPN-D's employee records lacked documentation the following orientation topics were completed: -An overview of the appropriate Assisted Living statutes 144.G and rules; -Handling of emergencies and use of emergency services; -Compliance with and reporting the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC);	01470		

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01470	Continued From page 18 -Handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; -Consumer advocacy services; -Provider's scope of license and types of assisted living services the employee would provide; and -Review of the principles of person-centered planning and service delivery.. During interview on March 8, 2023, at 12:40 p.m., licensed assisted living director (LALD)-C stated he believed all unlicensed staff had received orientation to the Minnesota assisted living statutes including person centered planning and service delivery. The licensee's New Hire Orientation policy dated July 12, 2012, indicated the licensee will provide consistent orientation to all new staff. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff	01650		

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01650	Continued From page 19 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 service plans included the method of supervision and monitoring of staff for four of four residents (R1, R2, R3, R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 admitted to the licensee on September 17, 2020. R1's diagnoses included essential hypertension.	01650		

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01650	Continued From page 20 R1's service plan dated June 29, 2022, indicated R1 required assistance with personal cares and medication administration. R2 admitted to the licensee on October 20, 2020. R2's diagnoses included hyperlipidemia. R2's service plan dated June 20, 2022, indicated R2 required assistance with medication administration. R3 admitted to the licensee on September 1, 2020. R3's diagnoses included hyperlipidemia. R3's service plan dated June 27, 2022, indicated R3 required assistance with medication administration. R4 admitted to the licensee on July 6, 2016. R4's diagnoses included essential hypertension. R4's service plan dated July 18, 2022, indicated R4 required assistance with medication administration. R1, R2, R3, and R4's service plans lacked the method of supervision and monitoring of staff. During an interview on March 8, 2023, at 2:40 p.m., licensed assisted living director (LALD)-C indicated he was not aware the service plan lacked the method of supervision and monitoring of staff. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01650		

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02040	Continued From page 21	02040		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to provide hazard vulnerability assessment or safety risk assessment of the physical environment on and around the property for the facility. This deficient practice had the ability to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: A record review of the available documentation and interview was conducted on March 8, 2023,	02040		

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02040	Continued From page 22 at approximately 10:00 a.m. with the Interim Resident Director (LALD)-C and the Maintenance Supervisor (MD)-G on the hazard vulnerability assessment for the physical environment of the facility. The record review indicated that the licensee had not performed a hazard vulnerability assessment with mitigation factors on and around the property. During the interview, MD-G stated that the licensee had not performed a hazard vulnerability assessment for the physical environment on or around the property. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		
02140 SS=F	144G.83 Subd. 3 Supervising staff training Persons providing or overseeing staff training must have experience and knowledge in the care of individuals with dementia, including: (1) two years of work experience related to Alzheimer's disease or other dementias, or in health care, gerontology, or another related field; and(2) completion of training equivalent to the requirements in this section and successfully passing a skills competency or knowledge test required by the commissioner. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to designate a qualified person to oversee staff training in the care of individuals with dementia. 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	02140		

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02140	Continued From page 23 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: Registered nurse (RN)-A had a hire date of April 5, 2017, and provided supervision and training to unlicensed personnel (ULP) in the licensee's assisted living with dementia care establishment. RN-A's employee record lacked documentation of completion of an approved competency and knowledge test as required for supervising staff in an assisted living facility with dementia care. During the entrance conference on March 7, 2023, at approximately 10:30 a.m., RN-A stated she oversaw training staff in the care of individuals with dementia. On March 8, 2023, at approximately 10:00 a.m., RN-A stated she had not completed an approved competency and knowledge test required for supervising staff in an assisted living facility with dementia care. During interview on March 8, 2023, licensed assisted living director (LALD)-C stated there were no other staff members hired by licensee that had completed an approved competency and knowledge test required for supervising staff in an assisted living facility with dementia care. No further information was provided. TIME PERIOD TO CORRECT: Twenty-One (21) days	02140		

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

Type: Full
Date: *03/07/23*
Time: 12:00:00
Report: 8041231047

Food and Beverage Establishment Inspection Report

Location:
Elder Homestead
11400 4th Street North
Minnetonka, MN55343
Hennepin County, 27

Establishment Info:
ID #: 0037562
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 9522832600
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.

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

Met on site with George Paulson (Facility Director) and Holly Heath (Food Service Manager- Cura). Elyse Jones was the RN with the Health Regulation Division completing a site survey.

The food service area in this assisted living facility is ran by Cura (third party) and will be licensed and inspected by the delegated agency (City of Minnetonka).

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 8041231047 of 03/07/23.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /

Inspection report reviewed with person in charge and emailed.

Signed:_____
Holly Heath
Manager- Cura

Signed: 
Sarah Conboy
Public Health Sanitarian III
651-201-3984
sarah.conboy@state.mn.us