DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

June 16, 2022

Administrator
English Rose Suites
609 Blake Road South
Edina, MN 55343

RE: Project Number SL20426015

Dear Administrator:

On May 25, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine if orders from the December 8, 2021, evaluation were corrected. This follow-up evaluation verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

Jess Gallmeier, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: jess.gallmeier@state.mn.us
Phone: 651-247-0268 Fax: 651-215-9697

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Electronically Delivered

January 24, 2022

Administrator
English Rose Suites
609 Blake Road South
Edina, MN 55343

RE: Project Number(s) SL20426015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on December 8, 2021, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

Level 1: no fines or enforcement.
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

In accordance with Minn. Stat. § 144G.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation

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

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5)(b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

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

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

The total amount you are assessed is $3,000.00. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

A state licensing order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557. Please email general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

Please address your cover letter for general reconsideration requests to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

Free from Maltreatment reconsideration requests should addressed to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. Requests for hearing may be emailed to **Health.HRD.Appeals@state.mn.us**.

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

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

Sincerely,

Jessica Gallmeier, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: jess.gallmeier@state.mn.us
Phone: 651-247-0268 Fax: 651-215-9697

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20426	A. BUILDING: _____ B. WING _____	12/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENGLISH ROSE SUITES	609 BLAKE ROAD SOUTH EDINA, 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 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: SL20426015 On December 6, 2021, through December 8, 2021, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were four residents receiving services under the provider's Assisted Living with 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 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.	
0 110 SS=F	144G.10 Subdivision 1a Assisted living director license required Each assisted living facility must employ an assisted living director licensed or permitted by	0 110		

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0 110	Continued From page 1 the Board of Executives for Long Term Services and Supports. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the licensed assisted living director (LALD)-C was listed as the Director of Record for the licensee and had applied to be shared director for all of the company's other licenses. This had the potential to affect all the licensee's residents, staff, and visitors. This resulted in an immediate correction order. 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: LALD-C started employment on December 17, 2011, under the comprehensive home care license and began providing assisted living services on August 1, 2021. On December 6, 2021, at approximately 10:10 a.m., during the entrance conference, a request was made to see LALD-C 's Minnesota Board of Executives for Long-Term Services and Support (BELTSS) license. On December 6, 2021, at 1:37 p.m., an email from BELTSS indicated LALD-C held a current LALD license, but LALD-C was not listed as the	0 110		

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0 110	Continued From page 2 Director of Record for any licensee. The email also stated LALD-C did not apply for a shared director status. On December 6, 2021, at approximately 10:45 a.m., during an interview, LALD-C stated she was the LALD for the licensee and stated she did not know if she had a shared director for all the company's other licenses. A policy related to a Licensed Assisted Living Director was requested, but not provided. No further information was provided Time Period to correct: IMMEDIATE On December 7, 2021, immediacy removed as confirmed by document review and BELTSS website verification by evaluation supervisor.	0 110		
0 430 SS=D	144G.40 Subd. 2 Uniform checklist disclosure of services (a) All assisted living facilities must provide to prospective residents: (1) a disclosure of the categories of assisted living licenses available and the category of license held by the facility; (2) a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and (3) an oral explanation of the services offered under the contract. (b) The requirements of paragraph (a) must be completed prior to the execution of the assisted	0 430		

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0 430	Continued From page 3 living contract. (c) The commissioner must, in consultation with all interested stakeholders, design the uniform checklist disclosure form for use as provided under paragraph (a). This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a copy of the uniform disclosure of assisted living services and amenities (UDALSA) with the required content for one of two residents (R1) with records reviewed. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a 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 admitted to licensee on October 22, 2021. R1's service plan titled, Planned Services, dated October 27, 2021, indicated R1 received services, including medication management, catheter care, housekeeping, dressing, laundry, bathing assistance, meal assistance, monitor glucose, behavior, grooming, toileting, and safety checks. R1's record lacked documentation of acknowledgement or receipt of the UDALSA including: (1) a disclosure of the categories of assisted	0 430		

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0 430	Continued From page 4 living licenses available and the category of license held by the facility; (2) a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and (3) an oral explanation of the services offered under the contract. During an interview on December 6, 2021, at approximately 12:40 p.m., licensed assisted living director (LALD)-C stated R1 had not received a written checklist listing all services provided and not provided under the facility's assisted living license. LALD-C stated they will update R1's record. The licensee's Uniform Disclosure of Assisted Living Services and Amenities policy, dated August 1, 2021, indicated "[licensee] will provide a "Uniform Disclosure of Assisted Living Services and Amenities" (UDALSA) to prospective residents prior to signing an Assisted Living contract." The policy further indicated, "The facility will obtain written acknowledgement from the resident or resident representative that [licensee] provided the UDALSA or document the reason why an acknowledgement was not obtained." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 430		
0 630 SS=E	144G.42 Subd. 6 Compliance with requirements for reporting ma	0 630		

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0 630	Continued From page 5 (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include statements of the specific measures to be taken to minimize the risk of abuse for one of two residents (R1) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1 admitted to licensee on October 22, 2021. R1's Service Plan, dated October 27, 2021, indicated R1 was receiving services including	0 630		

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0 630	Continued From page 6 behavior management, safety checks and transfer assist. R1's IAPP, dated November 30, 2021, identified vulnerabilities including fall risk, mobility, toileting, decreased physical strength, vision, verbally abusive, and memory loss. R1's IAPP lacked statements of specific measures to be taken to minimize the risk of abuse. During an interview on December 7, 2021, at 11:45 a.m., licensed assisted living director (LALD)-C and registered nurse (RN)-A stated the vulnerability assessment lacked interventions to minimize risk of abuse, and RN-A will update the IAPP. The licensee's policy titled, Individual Abuse Prevention Plan, dated August 2021, indicated the licensee will develop and implement an IAPP for each vulnerable adult. The policy did not specify to include interventions to minimize the risk of abuse. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 650 SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this	0 650		

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0 650	Continued From page 7 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. (b) Each employee record must be retained for at least three years after a paid employee, volunteer, or contractor ceases to be employed by, provide services at, or be under contract with the facility. If a facility ceases operation, employee records must be maintained for three years after facility operations cease. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure employee records included all required content for one of one employee (unlicensed personnel (ULP)-B) with employee record reviewed. This practice resulted in a level two violation (a violation that did not harm a client'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	0 650		

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0 650	Continued From page 8 situation has occurred only occasionally). The findings include: ULP-B started employment on June 17, 2021, under the comprehensive home care license and began providing assisted living services on August 1, 2021. On December 7, 2021, from approximately 7:40 a.m. through 9:30 a.m., the surveyor observed ULP-B providing assisted living services, including medication administration, bed making and serving breakfast for the licensee's residents. ULP-B's record lacked evidence of completed training and competencies at hire to include: - maintenance of a clean and safe environment - appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing (ii) care of teeth, gums, and oral prosthetic devices (iii) care and use of hearing aids (iv) dressing and assisting with toileting - standby assistance techniques and how to perform them - medication, exercise, and treatment reminders - basic nutrition, meal preparation, food safety, and assistance with eating - preparation of modified diets as ordered by a licensed health professional - procedures to utilize in handling various emergency situations - awareness of commonly used health technology equipment and assistive devices - basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel	0 650		

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0 650	Continued From page 9 - reading and recording temperature, pulse, and respirations of the client - safe transfer techniques and ambulation - range of motioning and positioning - administering medications or treatments as required - Other RN/professionally delegated tasks (e.g., monitor vital signs, catheter or stoma care, Broda chair, mechanical lifts). During an interview on December 8, 2021, at approximately 12:55 p.m., licensed assisted living director (LALD)-C indicated the licensee conducted the required training with ULP-B, but was not sure why the information was missing from ULP-B's record. LALD-C stated she was going to look into it further. The licensee's training and competencies policy was requested but not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		
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;	0 680		

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0 680	Continued From page 10 (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to complete a written emergency disaster plan with all required content and to post the emergency plan prominently. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on December 6, 2021, at approximately 9:20 a.m., the surveyor	0 680		

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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
0 680	Continued From page 11 requested to review the licensee's emergency disaster preparedness plan. During a facility tour on December 6, 2021, at approximately 10:45 a.m., the surveyor did not observe a posting regarding the licensee's emergency plan. The surveyor did not observe emergency exit diagrams posted in conspicuous places on each floor, or emergency exit diagrams in each of the four residents' rooms. The licensee's undated emergency disaster preparedness plan lacked evidence of the following required content: - process for emergency preparedness (EP) cooperation with state and local EP officials/organizations - procedure for tracking staff and residents - subsistence needs for staff and residents during emergency situation - development of policies/procedures to address: - a tracking system used to document locations of residents and staff - the medical record documentation system to preserve resident information - emergency staff strategies - the facilities role in providing care and treatment at alternative sites - a communication plan that included: - arrangement with other facilities - names and contact information for staff, resident physicians, other facilities - contact information for federal, state, tribal, local EP staff, ombudsman - primary and alternative means for communicating with facility staff, federal, state, regional and local emergency management agencies - a method of sharing information and medical documentation for residents	0 680		

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0 680	Continued From page 12 - a means to provide information regarding the facility's needs, and its ability to provide assistance to include information about their occupancy -a method of sharing information from the emergency plan with residents and their families - EP training and testing program - EP training program for staff (including documentation of training provided) - EP testing/annual testing requirements. During an interview on December 8, 2021, at approximately 12:10 p.m., licensed assisted living director (LALD)-C confirmed the licensee's emergency preparedness plan lacked required content. LALD-C stated the licensee will update the licensee's plan with the required content. The licensee's policy titled, Emergency Preparedness, dated August 1, 2021, indicated the licensee will have an identified plan in place to assure the safety and well-being of residents and staff during periods 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:	0 780		

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0 780	Continued From page 13 (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 as required in MN Statute 144G.45 subd. 2(a)(1). This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident 's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include:	0 780		

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0 780	Continued From page 14 During a facility tour with maintenance staff (MS)-D on December 7, 2021, between approximately 10:30 a.m. and 11:40 a.m., the surveyor observed upon testing, the smoke alarms were not interconnected so that actuation of one alarm causes all alarms to operate as required when there is more than one smoke alarm in a dwelling unit. The deficient condition was verified by MS-D. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
0 800 SS=D	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment, 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 as required in MN Statute 144G.45 subd. 2(a)(4). This had potential to affect all residents, staff, and visitors.	0 800		

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0 800	Continued From page 15 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: During a facility tour with maintenance staff (MS)-D on December 7, 2021, between approximately 10:30 a.m. and 11:40 a.m., the surveyor observed the toilet on the main level bathroom was not properly secured down to the floor, which posed a stability risk for anyone using the toilet. This deficient condition was verified by MS-D. 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	0 810		

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0 810	Continued From page 16 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 have fire safety and evacuation plans readily available at all times in the facility and failed to perform evacuation drills twice per year per shift with at least one evacuation drill every other month, as required by MN Statute 144G.45 Subd.2 (d) and (f). This deficient practice 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	0 810		

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0 810	Continued From page 17 problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During facility tour with maintenance staff (MS)-D on December 7, 2021, between approximately 10:30 a.m. and 11:40 a.m., the surveyor observed that there were no fire safety and evacuation plans posted throughout the facility; the only fire safety and evacuation plan posted was found on the second floor, which is not accessible to visitors or residents. This deficient condition was visually verified by MS-D accompanying on the tour. The surveyor reviewed licensee fire safety and evacuation plans and the employee evacuation drills. The licensee did not have the fire safety and evacuation plan readily available at all times in the facility. Additionally, the licensee did not have documentation indicating the licsensee conducted any evacuation drills. During an interview on December 7, 2021, between approximately 10:05 a.m. and 10:30 a.m., MS-D indicated the fire safety and evacuation plan was posted in areas throughout the facility. MS-D stated the licensee did not have records of conducting evacuation drills for employees at the time of survey. The licensee provided a policy on evacuation drills that prescribed guidelines in compliance with MN Statute 144G.45 Subd. 2(f). TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		

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01420 SS=D	144G.62 Subd. 2 Delegation of assisted living services (b) When the registered nurse or licensed health professional delegates tasks to unlicensed personnel, that person must ensure that prior to the delegation the unlicensed personnel is trained in the proper methods to perform the tasks or procedures for each resident and is able to demonstrate the ability to competently follow the procedures and perform the tasks. If an unlicensed personnel has not regularly performed the delegated assisted living task for a period of 24 consecutive months, the unlicensed personnel must demonstrate competency in the task to the registered nurse or appropriate licensed health professional. The registered nurse or licensed health professional must document instructions for the delegated tasks in the resident's record. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the registered nurse (RN) conducted training and competency evaluations for one of one unlicensed personnel (ULP)-B who performed delegated tasks. This practice resulted in a level two violation (a violation that did not harm a client'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:	01420		

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01420	Continued From page 19 ULP-B started employment with licensee on June 17, 2021, under the comprehensive home care license and began providing assisted living services on August 1, 2021. ULP-B's employee record lacked evidence of completed training and competency evaluation for medication administration. On December 7, 2021, from approximately 7:40 a.m. through 9:30 a.m., the surveyor observed ULP-B providing assisted living services to residents, including medication administration, bed making and serving breakfast. On December 8, 2021, at approximately 12:45 p.m., licensed assisted living director (LALD)-C acknowledged ULP-B's record lacked documentation of trainings and competencies, and stated ULP-B completed training but the licensee had misplaced the records. The licensee's policy for training and competencies was requested but not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01420		
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	01470		

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01470	Continued From page 20 person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated	01470		

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01470	Continued From page 21 age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employees received orientation to assisted living statutes with the required content for one of one employee unlicensed personnel (ULP)-B with record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-B started employment with the licensee on June 17, 2021, under the comprehensive home care license and began providing assisted living services on August 1, 2021. ULP-B's employee record lacked evidence indicating ULP-B received orientation on the following topics: - Overview of Assisted Living statutes - Review of provider's policies and procedures - Assisted Living bill of rights	01470		

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01470	Continued From page 22 - Review of types of Home Care/Assisted Living services the employee will provide and provider's scope of license - Principles of person-centered planning/service delivery On December 8, 2021, at approximately 12:40 p.m., licensed assisted living director (LALD)-C and registered nurse (RN)-A verified ULP-B's record lacked orientation to assisted living licensing requirements and regulations, and stated ULP-B had not completed the assisted living licensure orientation and none of the licensee's employees either, and that the licensee will update the employees records. The licensee's orientation policy was requested but was not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01470		
01620 SS=D	144G.70 Subd. 2 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	01620		

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01620	Continued From page 23	01620		

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.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to ensure a registered nurse (RN) conducted a reassessment, not to exceed 14 calendar days from the initiation of services, for one of two residents (R1) with records reviewed.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).

The findings include:

R1 was admitted to the licensee on October 20, 2021. R1's diagnoses included memory loss and diabetes.

R1's service plan titled, Planned Services, dated October 27, 2021, indicated R1 received services, including medication management,

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01620	Continued From page 24 catheter care, housekeeping, dressing, laundry, bathing assistance, meal assistance, glucose monitoring, behavior, grooming, toileting, and safety checks. R1's initial comprehensive assessment was dated and signed on October 22, 2021. The 14-day monitoring and reassessment was dated and signed on November 30, 2021, which was more than the required 14 calendar days after initiation of services. During an interview on December 7, 2021, at approximately 2:05 p.m., RN-A confirmed R1's 14-day monitoring and re-assessment was not completed within 14 days as required. The licensee's monitoring and reassessment policy was requested but not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01650 SS=F	144G.70 Subd. 4 Service plan, implementation, and revisions t (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and	01650		

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01650	Continued From page 25 (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 resident service plans included the required content for two of two residents (R1 and R2) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a 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 was admitted to the licensee on October 22, 2021. R1's diagnoses included memory loss and diabetes.	01650		

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01650	Continued From page 26 R1's service plan, signed and dated October 27, 2021, indicated R1 received services including medication management, housekeeping, dressing, laundry, bathing assistance, meal assistance, glucose monitoring, behavior, grooming, toileting, and safety checks. R1's service plan lacked catheter care, the identification of staff or categories of staff who will provide the services, and the schedule and methods of monitoring staff providing services. R2 was admitted on October 28, 2021. R2's diagnoses included dementia and hypertension. R2's service plan, signed and dated October 28, 2021, indicated R2 received services including medication administration, bathing, shampoo, personal care, assistance with ambulation, toileting, laundry, and housekeeping. R2's service plan lacked the identification of staff or categories of staff who will provide the services and the schedule and methods of monitoring staff providing services. On December 8, 2021, at approximately 1:20 p.m., licensed assisted living director (LALD)-C and registered nurse (RN)- A acknowledged the missing content should be included in resident service plans. LALD-C and RN-A stated they will work to update all their residents' service plans. The licensee's policy for service plan requested but was not provided. No further information was provided. TIME PERIOD FOR CORRECTION:	01650		

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01650	Continued From page 27 Twenty-One (21) days	01650		
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions.	01730		

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01730	Continued From page 28 (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop an individualized medication management plan with the required content for two of two residents (R1 and R2) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 was admitted to the licensee on October 22, 2021. R1's service plan, signed and dated October 27, 2021, indicated R1 received services, including medication management, housekeeping, dressing, laundry, bathing assistance, meal assistance, behavior, grooming, toileting, and safety checks. R1's Individualized Medication Management Plan dated November 30, 2021, lacked documentation	01730		

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01730	Continued From page 29 of the procedures for when staff should notify a registered nurse (RN) or appropriate licensed health professional when a problem arises and identification of medication management tasks that may be delegated to unlicensed personnel (ULPs). R2 was admitted to the licensee on October 25, 2021. R2's service plan, signed and dated October 28, 2021, indicated R2 received services, including medication management, bathing, shampoo, personal care, assistance with ambulation, toileting, laundry, and housekeeping. R2's Individualized Medication Management Plan dated October 28, 2021, lacked documentation of the procedures for when staff should notify a RN or appropriate licensed health professional when a problem arises and identification of medication management tasks that may be delegated to ULPs. On December 8, 2021, at approximately 1:00 p.m., RN-A acknowledged the missing content should be included individualized medication management plans. RN-A stated the residents' records will be updated. The licensee's medication management plan policy was requested but not provided. No further information was provided. Time period for correction: Seven (7) days	01730		
01890 SS=D	144G.71 Subd. 20 Prescription drugs	01890		

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01890	Continued From page 30 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 ensure expired medications were properly disposed of for one of two residents (R2) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2's physician orders dated November 2, 2021, indicated R2's prescriptions included: acetaminophen 325 mg by mouth two times a day, amlodipine 2.5 mg by mouth two times a day, memantine hcl 10 mg by mouth two times a day, senna-s 8.6-50 mg by mouth two times a day, and ibuprofen 600 mg tab by mouth three times daily as needed. On December 7, 2021, at approximately 9:30 a.m., the surveyor observed unlicensed personnel (ULP)-B administer medications to R2.	01890		

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01890	Continued From page 31 On December 7, 2021, at approximately 10:20 a.m., the surveyor observed the contents of R2's medication box and noted the following expired medications: - naproxen 220 milligram (mg) - senna-s 8.6-50mg - omeprazole capsules 20 mg - senexon-s 8.6-50 mg - therems multivitamin 400 mg - ondansetron 4 mg - hydroxyzinepamoate 25 mg - melatonin 3 mg - ferrous sulphate 325 mg - benzonatate 100 mg - bupropion xl 150 mg - mirtazapine f/c 15 mg On December 8, 2021, at approximately 1:40 p.m., registered nurse (RN)-A acknowledged R2 had expired medications in the medication box. RN-A stated all resident medications are labeled, and the nurses checks to ensure the medications are not expired. The licensee's policy titled, Medications and Treatments (Medication Disposal), dated August 2021, indicated the licensee will dispose of expired medications according to the accepted practices of the Minnesota Board of Pharmacy and the labels will be destroyed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen	01940		

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01940	Continued From page 32 For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop a treatment management plan with all required content for one of one resident (R1) who received treatment with the record reviewed. This practice resulted in a level two violation (a	01940		

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01940	Continued From page 33	01940		

violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).

The findings include:

R1 was admitted to the licensee on October 22, 2021. R1's diagnoses included diabetes and memory loss.

R1's service plan, signed and dated October 27, 2021, indicated R1 received services, including medication management, housekeeping, dressing, laundry, bathing assistance, meal assistance, behavior, grooming, toileting, and safety checks.

R1's undated Individual Treatment and Therapy Plan indicated R1 received catheter care and blood glucose monitoring. R1's Individual Treatment and Therapy Plan lacked the identification of treatment or therapy tasks delegated to unlicensed personnel (ULPs) and procedures for notifying a registered nurse (RN) or appropriate licensed health professional when a problem arises with treatments or therapy services.

R1's Vital Sign Log dated between November 22, 2021, and December 7, 2021, indicated R1 received blood glucose monitoring at least three times a day with results ranging between 78 and 329 (normal blood sugar results are 70-110).

R1's Service Recap Summary dated December

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01940	Continued From page 34 2021 indicated ULPs documented completing catheter care for R1. During an interview on December 8, 2021, at approximately 10:00 a.m., RN-A acknowledged the missing content from R1's treatment plan and stated she will update the treatment plan. The licensee's policy, Medication and Treatment (Treatment and Therapy Management Plan), dated August 2021, indicated the missing content was supposed to be included. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
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 a hazard vulnerability assessment or a safety risk of the physical	02040		

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02040	Continued From page 35 environment specific to the licensee, as required by MN Statute 144G.81 Subd.1 (a). This deficient practice 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). The findings include: The surveyor conducted a record review of the hazard vulnerability assessment for the physical environment of the licensee. The licensee did not have a record of a hazard vulnerability assessment for the physical environment on or around the property. During an interview on December 7, 2021, between approximately 10:05 a.m. and 10:30 a.m., maintenance staff (MS)-D indicated the licensee had not conducted a hazard vulnerability assessment of the physical environment for the licensee. A policy was requested for the hazard vulnerability assessment, but was not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		

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02110	Continued From page 36	02110		
02110 SS=F	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in.	02110		

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02110	Continued From page 37 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the required policies and procedures were provided to each resident and/or the resident's legal and designated representative at the time of move-in for two of two residents (R1 and R2) with records reviewed. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1's record was reviewed. R1 was admitted to the licensee on October 22, 2021. R1's record lacked documentation of receipt of required policies and procedures to be provided by licensee at the time of move-in. R2's record was reviewed. R2 was admitted to the licensee on October 28, 2021. R2's record lacked documentation of receipt of required policies and procedures to be provided by licensee at the time of move-in. On December 7, 2021, at approximately 11:30 a.m., registered nurse (RN)-A stated the policy packet was created but was not provided to any residents receiving services by the licensee. The licensee's Assisted Living with Dementia Care Policies and Procedures Disclosure (144G.82) dated August 2021 indicated all	02110		

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02110	Continued From page 38 policies and procedures required to be disclosed prior to move-in. The licensee's Dementia Memory Care Facility Program Disclosure Requirements policy was requested but not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02110		
02310 SS=G	144G.91 Subd. 4 Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care standards, medical or nursing standards for one of one resident (R2) who utilized bed rails with record reviewed. 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).	02310		

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02310	Continued From page 39 The findings include: On December 7, 2021, at approximately 8:30 a.m. unlicensed personnel (ULP)-B assisted R2 into her wheelchair from her bed. R2's bed had a bed rail on the right side, which was rectangular shaped and measured 13 inches in width, and 8 inches in height (in the mid-section). The bed rail was one piece with crossbars opening to less than four inches wide. ULP-B indicated the bed rail could easily be moved back and forth and was not secured to the bed frame. ULP-B lifted R2's mattress and R2's bed rail was one piece and not bolted or otherwise secured to the bed frame. The surveyor grasped the side rail, and it easily moved. The surveyor did not observe a gap between the bed rail and R2's mattress. R2 was admitted to the licensee on October 25, 2021. R2's diagnoses included dementia and hypertension. R2's record contained an assessment, titled Bed Rail Acknowledgement Form, signed and dated August 1, 2021, by R2 and registered nurse (RN)-A, indicated R2 consented to have a bed rail installed properly. The assessment did not specify which side of R2's bed the bed rail would be installed. R2's service plan, dated October 28, 2021, indicated R2 received services including medication management, bathing, personal care, assist with ambulation, exercise, and daily assist with meal prep and set up. On December 8, 2021, at approximately 10:10 a.m., RN-A acknowledged R2's bed rail was not properly installed and stated the maintenance team would work to install it properly.	02310		

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	20426	A. BUILDING: _____ B. WING _____	12/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENGLISH ROSE SUITES	609 BLAKE ROAD SOUTH EDINA, 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
02310	Continued From page 40 The licensee's Side Rail policy, dated August 2021, indicated the licensee will assess the use, educate the resident, and when appropriate, the responsible person regarding the risks and benefits of side rails and verify the side rail is of safe design and utilized consistent with the manufacturer's direction. The Food and Drug Administration's (FDA), A Guide to Bed Safety, revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE On January 14, 2022, immediacy removed as confirmed by communication from licensee and evaluation supervisor.	02310		

Minnesota Department of Health

625 North Robert Street
Saint Paul, MN
651-201-5000

Type: Full
Date: *12/07/21*
Time: 09:30:00
Report: 8087211319

Food and Beverage Establishment Inspection Report

Location:
English Rose Suites
609 Blake Road South
Edina, MN55343
Hennepin County, 27

Establishment Info:
ID #: 0039265
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 9529830412
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.

Food and Equipment Temperatures

Process/Item: Ambient Air
Temperature: 4 Degrees Fahrenheit - Location: BASEMENT DEEP FREEZER
Violation Issued: No

Process/Item: Ambient Air
Temperature: 14 Degrees Fahrenheit - Location: BASEMENT STAND-UP FREEZER
Violation Issued: No

Process/Item: Ambient Air
Temperature: 38 Degrees Fahrenheit - Location: BASEMENT STAND-UP REFRIGERATOR
Violation Issued: No

Process/Item: Cold Holding: MILK
Temperature: 40 Degrees Fahrenheit - Location: BASEMENT STAND-UP REFRIGERATOR
Violation Issued: No

Process/Item: Cold Holding: DELI MEAT
Temperature: 39 Degrees Fahrenheit - Location: BASEMENT STAND-UP REFRIGERATOR
Violation Issued: No

Process/Item: Ambient Air
Temperature: 39 Degrees Fahrenheit - Location: KITCHEN STAND-UP REFRIGERATOR
Violation Issued: No

Process/Item: Cold Holding: CHEESE
Temperature: 40 Degrees Fahrenheit - Location: KITCHEN STAND-UP REFRIGERATOR
Violation Issued: No

Process/Item: Cold Holding: SOUR CREAM
Temperature: 39 Degrees Fahrenheit - Location: KITCHEN STAND-UP REFRIGERATOR
Violation Issued: No

Process/Item: Cold Holding: ALMOND MILK
Temperature: 39 Degrees Fahrenheit - Location: KITCHEN STAND-UP REFRIGERATOR
Violation Issued: No

Process/Item: Ambient Air
Temperature: 3 Degrees Fahrenheit - Location: KITCHEN FREEZER
Violation Issued: No

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

THIS WAS AN ANNOUNCED AND SCHEDULED FULL INSPECTION.

INSPECTION CONDUCTED IN THE PRESENCE OF NURSE EVALUATOR II BENARD NYANGENA (HRD SURVEY STAFF SUPERVISOR).

FLOORS AND CABINETS ARE HARDWOOD AND CEILING APPEARS TO BE DURABLE, SMOOTH IN TEXTURE AND EASILY CLEANABLE. ALL ARE FOUND TO BE IN GOOD CONDITION AND WILL BE MONITORED AT FUTURE INSPECTIONS. IF AT SUCH A TIME THEY ARE FOUND TO BE A CONCERN OR RISK OF CONTAMINATION, THEY WILL BE ORDERED TO BE REPLACED AND BROUGHT UP TO CODE.

KITCHENAID BRAND DISHWASHER IS RESIDENTIAL BUT HAS SANITIZING RINSE CYCLE OPTION.

HOT WATER TEMPERATURE AT THE KITCHEN SINK REACHED 120 DEGREES.

NO DESIGNATED HAND WASHING SINK IN THE KITCHEN, ONLY A 2-BIN, STAINLESS STEEL RESIDENTIAL KITCHEN SINK.

INSPECTION REPORT EMAILED TO BENARD NYANGENA (HRD SURVEY STAFF SUPERVISOR).

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 8087211319 of 12/07/21.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /

Inspection report reviewed with person in charge and emailed.

Signed:_____

BENARD NYANGENA
NURSE EVALUATOR II

Signed:_____

John Boettcher
Public Health Sanitarian 3
St. Paul, MN / Freeman
651-201-5076
john.boettcher@state.mn.us