Electronically Delivered

March 27, 2025

Licensee
Ultimate Care Assisted Living Regent House
7508 Scott Avenue North
Brooklyn Park, MN 55443

RE: Project Number(s) SL30064016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on February 20, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

MDH concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

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

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

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

0780 - 144g.45 Subd. 2 (a) (1) - Fire Protection And Physical Environment - $500.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

To submit a hearing request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,

Renee L. Anderson

Renee Anderson, Supervisor
State Evaluation Team
Email: renee.anderson@state.mn.us
Telephone: 651-201-5871 Fax: 1-866-890-9290

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30064	A. BUILDING: _____ B. WING _____	02/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ULTIMATE CARE ASSISTED LIVING REGENT H	7508 SCOTT AVENUE NORTH BROOKLYN PARK, MN 55443

(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 In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL30064016-0 On February 18, 2025, through February 20, 2025, 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 zero (0) residents receiving services under the provider's Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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0 480	Continued From page 1 (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are	0 480		

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0 480	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated February 18, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		

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0 630 SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) contained statements of the specific measures to be taken by staff to minimize the risk of abuse for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 had diagnoses including, but not limited to, status-post alcohol use with withdrawal, depression, and chronic post-procedural pain.	0 630		

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0 630	Continued From page 4 R1's plan of care, dated January 19, 2023, indicated R1 received services including assistance with bathing, activities of daily living (ADLs), toileting, meals, and medication management. R1's IAPP, titled, "Vulnerable Adult Assessment," dated January 19, 2023, identified R1's vulnerabilities, including R1 was vulnerable in the following areas: -limited decision making, -mental or financial exploitation, -sensory deficit present that would affect safety, -functional limitation that would affect safety, -risk of abuse by others, and -dependency on caregiver. R1's IAPP lacked specific measures to be taken by staff to minimize the risk of abuse to R1 with identified vulnerabilities. On February 20, 2025, at 9:57 a.m., during a telephone interview, licensed assisted living director (LALD)-A stated they were unaware R1's IAPP was not completed accurately. LALD-A further stated the registered nurse (RN) responsible for ensuring assessments had been completed accurately was no longer employed with the licensee. The licensee's Vulnerable Adult policy dated February 17, 2022, indicated employees would be required to individually assess each resident upon admission to determine vulnerability to abuse or neglect and develop a specific plan to minimize the risk of abuse to that resident. The policy further indicated the plan would contain statements of specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults.	0 630		

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0 630	Continued From page 5 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment 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 interconnected smoke alarms in required locations. These deficient conditions had the ability to affect all staff and residents.	0 780		

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0 780	Continued From page 6 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: On February 19, 2025, at approximately 11:00 a.m., the surveyor toured the facility with licensed assisted living director (LALD)-A. During the tour, the surveyor observed the following: 1. A smoke alarm was not installed in the main-level hallway in the immediate vicinity of this sleeping rooms. 2. When smoke alarms were tested for interconnection by the licensee, the smoke alarms installed in upper-level and the lower-level were not actuated. The smoke alarms throughout the facility were not interconnected as required by statute. During the facility tour interview on February 19, 2025, LALD-A acknowledged the observation while accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
0 790 SS=F	144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code;	0 790		

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0 790	Continued From page 7 (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the portable fire extinguishers. This deficient condition 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On February 19, 2025, at approximately 11:00 a.m., the surveyor toured the facility with licensed assisted living director (LALD)-A. The portable fire extinguishers throughout the facility where not installed on their required wall mount brackets. On February 19, 2025, the surveyor explained to LALD-A that the portable fire extinguishers must be mounted to ensure all portable extinguishers are readily available, fully charged, and operable at their designated location. LALD-A stated they understood the requirements.	0 790		

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0 790	Continued From page 8 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff 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) Staff 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 staff 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.	0 810		

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0 810	Continued From page 9 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On February 19, 2025, licensed assisted living director (LALD)-A provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN: The licensee's FSEP failed to include the following: The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate) but the plan was designed for a building with life safety systems	0 810		

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0 810	Continued From page 10 such as fire alarms system and smoke compartments. The policy had not been updated to provide complete actions for employees to take in the event of a fire or similar emergency at the licensed facility which did not have life safety systems or a fire-resistant construction type. The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. The FSEP included standard resident evacuation procedures but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan included instructions to evacuate residents but did not include any procedures for assisting residents during evacuation nor did it include instructions for staff to follow in case of relocation. On February 19, 2025, LALD-A stated they understood the areas of their policy that were incomplete and would work on bringing them into compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted	01620		

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01620	Continued From page 11 as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing resident monitoring and reassessment, not to exceed 90 calendar days from the previous reassessment for one of one resident (R1). 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 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).	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30064	A. BUILDING: _____ B. WING _____	02/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ULTIMATE CARE ASSISTED LIVING REGENT H	7508 SCOTT AVENUE NORTH BROOKLYN PARK, MN 55443

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01620	Continued From page 12 The findings include: R1 had diagnoses to include, but not limited to status-post alcohol use with withdrawal, depression, and chronic postprocedural pain. R1's plan of care, dated January 19, 2023, indicated R1 received services including assistance with bathing, activities of daily living (ADLs), toileting, meals, and medication management. R1's record included documentation of a 90-day RN nursing reassessment completed September 22, 2023, an RN nursing reassessment completed January 11, 2024, which was completed greater than 90-days (110 days) from the previous reassessment, and an RN nursing reassessment completed on April 22, 2024, which was greater than 90-days (101 days) from the previous reassessment. On February 18, 2025, at 1:30 p.m., licensed assisted living director (LALD)-A stated licensee had an electronic tracking system in place which would trigger assessment due dates, and that he would verbally inform the RN when an assessment would be coming up. LALD-A further stated at times the nurse would be working on other tasks and following up on assessments would completely slip their mind. Moreover, LALD-A stated he lacked holding the RN accountable for ensuring assessments had been kept up to date. The licensee's Assessments and Reassessments policy dated February 17, 2022, indicated an individualized initial evaluation of all new residents would be completed by a RN in order to develop a personalized service plan, and the	01620		

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	30064	A. BUILDING: _____ B. WING _____	02/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ULTIMATE CARE ASSISTED LIVING REGENT H	7508 SCOTT AVENUE NORTH BROOKLYN PARK, MN 55443

(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
01620	Continued From page 13 assessment would be revised regularly and as appropriate. Furthermore, ongoing resident reassessments would be conducted by an RN and would not exceed 90 days from the last date of assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01770 SS=F	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure documentation of medication setup included all the required content for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	01770		

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	30064	A. BUILDING: _____ B. WING _____	02/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ULTIMATE CARE ASSISTED LIVING REGENT H	7508 SCOTT AVENUE NORTH BROOKLYN PARK, MN 55443

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01770	Continued From page 14 On February 18, 2025, at 10:30 a.m., during the entrance conference, licensed assisted living director (LALD)-A stated licensee provided medication management services, which included medication setup by the registered nurse (RN) into medication planner boxes (a plastic medication box with designated compartments for days and times), for later administration by unlicensed personnel (ULP). R1's Plan of Care, dated January 19, 2023, indicated R1 received services including assistance with medication management. The Plan of Care further indicated the nurse set up the meds in a medication box weekly, and ULP was to administer medications daily, according to orders. R1's Medication Assessment Plan, dated January 19, 2023, indicated R1 received medication management services to include medication setup in medication planner according to the scheduled medication administration times (a.m. or p.m.) by licensee's nurse and medication administration by trained ULP. R1's undated Resident Current Medication List included Aspirin Enteric Coated 81 milligram (mg), (used for aches and pains), Certavite SR with Lutein, (used as a vitamin supplement), cholecalciferol 1000 unit, (used for vitamin d deficiency), duloxetine 30mg, (used to treat depression), Fish Oil 1000mg, (used for supplement), folic acid 1mg, (used for supplement), Magnesium Sulfate 400mg, (used for supplement), methocarbamol 500mg, (used to relieve discomfort), pregabalin 50mg, (used for pain), rosuvastatin calcium 20mg, (used for cholesterol), spironolactone 50mg, (used for fluid buildup), acetaminophen 325mg, albuterol Inhaler	01770		

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01770	Continued From page 15 90 microgram (mcg), guaifenesin 400mg, (used for cough), MiraLAX 17 gram (GM),(used for constipation), nicotine gum 4mg, and ondansetron 4mg, (used for nausea and vomiting). R1's record lacked documentation by the licensed nurse, at the time of medication setup, to include: -the date of medication setup, -the name of the medication, -quantity of dose, and -route of administration. On February 20, 2025, at 9:57 a.m., LALD-A stated R1's medical record lacked the required documentation noted above. LALD-A further stated the RN who was responsible for medication management and medication setup, was no longer employed by licensee. In addition, LALD-A stated he was unaware of all the documentation requirements when the nurse completed medication setup. Moreover, licensee would be switching to pre-packaged medications, completed at the pharmacy, and delivered to the licensee, for ULP administration. The licensee's Medication Documentation policy dated February 17, 2022, indicated licensee would document medication setup according to the following: 1. Dates of medication setup; 2. Name of medication; 3. Quantity of dose; 4. Times to be administered; 5. Route of administration; and 6. Name/title of person completing medication setup at time of set-up. No further information was provided.	01770		

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01770	Continued From page 16 TIME PERIOD FOR CORRECTION: Seven (7) days	01770		
01910 SS=F	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document in the resident's record the disposition of medications, including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition for one of one discharged resident (R1).	01910		

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01910	Continued From page 17 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 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 January 19, 2023, and was discharged April 30, 2024. R1 had diagnoses to include, but not limited to status-post alcohol use with withdrawal, depression, and chronic postprocedural pain. R1's Plan of Care dated January 19, 2023, indicated R1 received services which included assistance with medication management. R1's undated Resident Current Medication List included Aspirin Enteric Coated 81 milligram (mg), (used for aches and pains), Certavite SR with Lutein, (used as a vitamin supplement), cholecalciferol 1000 unit, (used for vitamin d deficiency), duloxetine 30mg, (used to treat depression), Fish Oil 1000mg, (used for supplement), folic acid 1mg, (used for supplement), Magnesium Sulfate 400mg, (used for supplement), methocarbamol 500mg, (used to relieve discomfort), pregabalin 50mg, (used for pain), rosuvastatin calcium 20mg, (used for cholesterol), spironolactone 50mg, (used for fluid buildup), acetaminophen 325mg, albuterol Inhaler 90 microgram (mcg), guaifenesin 400mg, (used for cough), MiraLAX 17 gram (GM),(used for constipation), nicotine gum 4mg, and ondansetron 4mg, (used for nausea and	01910		

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01910	Continued From page 18 vomiting). R1's Discharge Summary dated April 30, 2024, indicated disposition of medication (if applicable) N/A. R1's record lacked documentation of disposition of medications including: -prescription number as applicable, -quantity, and -names of staff and other individuals involved in the disposition. On February 19, 2025, at 1:25 p.m., during a telephone interview, licensed assisted living director (LALD)-A stated all medications were given to R1 upon discharge; however, the registered nurse (RN) who completed the medication disposition documentation was no longer employed with the licensee. Furthermore, LALD-A stated he was unaware of all the documentation required for medication disposition. The licensee's Medication Documentation policy dated February 17, 2022, did not address medication disposition requirements. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services	01940		

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01940	Continued From page 19 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 and implement a treatment or therapy management plan to include all required content for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01940	Continued From page 20 a limited number of staff are involved or the situation has occurred only occasionally). Findings include: On February 18, 2025, at 10:30 a.m., during the entrance conference, licensed assisted living director (LALD)-A stated licensee provided treatment management services to residents, including, but not limited to, ace wrap and compression stocking assistance. R1's Home Health Aide Care Plan dated January 19, 2023, indicated R1 received services including assistance with activities of daily living (ADLs), bathing, skin care, foot care, medication management, weekly vital signs, range of motion, turning and repositioning, toileting, laundry, and housekeeping. R1's treatment service log dated January 15, 2025, indicated R1 received treatment services to include assistance with "ace wraps as needed". R1's treatment service log indicated R1 was assisted with ace wraps at 8:00 a.m., and 9:00 p.m., daily. R1's record lacked a treatment management plan to include the following required content: - documentation of specific resident instructions relating to the treatments or therapy administration; - identification of treatment or therapy tasks that would be delegated to unlicensed personnel; - procedures for notifying a registered nurse when a problem arose with treatments or therapy services; and - any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01940	Continued From page 21 treatment or therapy to prevent possible complications or adverse reactions. On February 20, 2025, at approximately 2:28 p.m., during an exit interview via telephone, LALD-A stated R1 was admitted to the Assisted Living Facility from a nursing home, and the registered nurse (RN) was responsible to ensure the discharge orders had been current, and signed by the physician. LALD-A further stated the RN who was responsible for R1's treatment orders is no longer employed with licensee. The licensee's Medication, Treatment & Therapy Management Services policy, revised September 2019, indicated based on the medication, treatment and/or therapy management assessment, the RN would develop an individualized management plan for each resident receiving any type of these services, consistent with current practice standards and guidelines, and would develop specific procedures for services that the staff would provide. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be	01970		

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01970	Continued From page 22 renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to obtain prescriber orders for all treatments and therapies, including the frequency, duration and other information needed to administer the treatment or therapy for one of one resident (R1) with record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's Home Health Aide Care Plan dated January 19, 2023, indicated R1 received services including assistance with activities of daily living (ADLs), bathing, skin care, foot care, medication management, weekly vital signs, range of motion, turning and repositioning, toileting, laundry, and housekeeping. R1's treatment service log dated January 15, 2025, indicated R1 received treatment services to include assistance with "ace wraps as needed". R1's treatment service log indicated R1 was assisted with ace wraps at 8:00 a.m., and 9:00 p.m., daily. R1's record lacked a signed prescriber order for application of ace wraps.	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01970	Continued From page 23 On February 20, 2025, at approximately 2:28 p.m., during an exit interview via telephone, LALD-A stated R1 was admitted to the Assisted Living Facility from a nursing home, and the registered nurse (RN) was responsible to ensure the discharge orders had been current, and signed by the physician. LALD-A further stated the RN who was responsible for R1's treatment orders is no longer employed with licensee. The licensee's Treatment and Therapy Management policy dated February 17, 2022, indicated the RN or licensed professional would prepare an individualized treatment or therapy management plan for each resident receiving ordered or prescribed treatments or therapy services, which addresses: a. Type of service to be provided. b. Procedures for documenting treatments or therapies. c. Procedures for monitoring treatments or therapies to prevent possible complications or adverse reactions. d. Identification of treatment or therapy tasks delegated to unlicensed personnel. e. Procedures for notifying the RN or licensed health professional when a problem arises related to the treatment or therapy service. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970		

Minnesota Department of Health

3333 Division St #212
St. Cloud
320 223-7300

Type: Full
Date: *02/18/25*
Time: 11:00:00
Report: 1051251040

Food and Beverage Establishment Inspection Report

Location:
Ultimate Care Assisted Living
7508 Scott Avenue North
Brooklyn Park, MN55443
Hennepin County, 27

Establishment Info:
ID #: 0037908
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7635609890
ID #:

The violations listed in this report include any previously issued orders and deficiencies identified during this inspection. Compliance dates are shown for each item.

The following orders were issued during this inspection.

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.

AT TIME OF INSPECTION, THERE IS NO CERTIFIED FOOD PROTECTION MANAGER.

Comply By: 03/18/25

Food and Equipment Temperatures

Process/Item: Upright Cooler
Temperature: 41 Degrees Fahrenheit - Location: AMBIENT
Violation Issued: No

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

MET WITH NURSE EVALUATOR, RHONDA MAKELA.

DISCUSSED THE FOLLOWING WITH THE MANAGER, ALFRED:

EMPLOYEE ILLNESS LOG
VOMIT CLEAN-UP PROCEDURE
HANDWASHING & GLOVE USE
CERTIFIED FOOD PROTECTION MANAGER

THE KITCHEN HAS A NSF 184 DISHWASHER, LAMINATE COUNTERTOPS WITH HOLLOW BASES, POPCORN TEXTURE CEILING, VINYL TILE FLOORS, & MDF WOODEN CABINETS.

Type: Full
Date: *02/18/25*
Time: 11:00:00
Report: 1051251040
Ultimate Care Assisted Living

Food and Beverage Establishment Inspection Report

THE FACILITY IS STILL UNDER RENOVATION AND IS PLANNING TO OPERATE IN SPRING 2025.

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 1051251040 of 02/18/25.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/ /_____

Inspection report reviewed with person in charge and emailed.

Signed:_____

Alfred
Manager/Director

Signed:_____

Kai Yang
Public Health Sanitarian 1
St. Cloud
320 640-3532
Kai.Yang@state.mn.us