Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

November 7, 2024

Licensee
Dis-Generation Group Inc
9032 Prestwick Parkway
Brooklyn Center, MN 55443

RE: Project Number(s) SL37713015

Dear Licensee:

On September 4, 2024, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on July 16, 2024. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the July 16, 2024 survey.

The Department of Health 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.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on July 16, 2024, found not corrected at the time of the September 4, 2024, follow-up survey and/or subject to penalty assessment are as follows:

0810-Fire Protection And Physical Environment-144g.45 Subd. 2 (b)-(f) - $500.00

The details of the violations noted at the time of this follow-up survey completed on September 4, 2024 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

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 outlined on the state form; however, plans of correction are not required to be submitted for approval.

IMPOSITION OF FINES:

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

§144G.20.

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

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

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

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

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

We urge you to review these orders carefully. If you have questions, please contact Benjamin J. Zwart at 651-201-3715.

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

Sincerely,

Benjamin J. Zwart, Supervisor
State Engineering Services Section
Health Regulation Division
Email: Benjamin.Zwart@state.mn.us
Telephone: 651-201-3715 Fax: 1-800-337-9238 / 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37713	A. BUILDING: _____ B. WING _____	R 09/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIS-GENERATION GROUP INC	9032 PRESTWICK PARKWAY BROOKLYN CENTER, 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: Project # SL37713015-1 On September 3, 2024, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on July 16 2024. As a result of the revisit, the following correction order is re-issued.	{0 000}		
{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	{0 810}		

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{0 810}	Continued From page 1 (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on document review and interview, the licensee failed to provide all required contents on the fire safety and evacuation plan and the minimum training of staff on the fire safety and evacuation plan. This has the potential to directly affect the safety of visitors, staff, and all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive	{0 810}		

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{0 810}	Continued From page 2 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 September 3, 2024, at approximately 1:30 p.m., document review and interview with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C and the housing manager (HM)-E. -Document review indicated the licensee's emergency preparedness plan (EPP) was incomplete. The EPP plan failed to include fire safety procedures including site-specific employee actions to take in the event of a fire or similar emergency. The LALD/CNS-C explained that they purchased a new comprehensive EPP with all required contents including fire safety to replace their existing plan. Survey staff asked the LALD/CNS-C to locate the fire safety plan within the home's new EPP and provide it for survey staff review but the LALD/CNS-C failed to locate the fire safety procedures. The LALD/CNS-C confirmed the deficient finding and placed a call to the seller to seek clarification. -Document review indicated the home's new evacuation content in the EPP binder incorrectly had their Jersey home information. The HM-E explained that he made a mistake by inserting the wrong document. -Document review indicated the plan lacked fire protection procedures for residents. No documentation was provided or available when requested. -Record review of available documentation	{0 810}		

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{0 810}	Continued From page 3 indicated that the licensee provide incomplete employee training on the fire safety and evacuation plan twice per year after the initial hire training. During an interview, the LALD/CNS-C provided an evacuation drill record dated, August 6, 2024, 10 a.m., with a note stating for all staff on the record, and explained to survey staff that they had conducted the drill as part of training. Survey staff explained to the LALD/CNS-C and the HM-E that employee training on fire safety and evacuation must be performed twice a year and evacuation drills are separate from fire safety and evacuation training. The above deficient findings were verified by the LALD/CNS-C during the interview. On September 3, 2024, at approximately 2:30 p.m., LALD/CNS-C and HM-E understood and acknowledged the above deficient findings during the interview. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	{0 810}		

Electronically Delivered

August 8, 2024

Licensee
Dis-Generation Group Inc.
9032 Prestwick Parkway
Brooklyn Center, MN 55443

RE: Project Number(s) SL37713015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 16, 2024, 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.

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.

In accordance with Minn. Stat. § 144G.31, Subd. 4(a)(5), MDH may impose fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. MDH may impose a fine of $1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. MDH also may impose a

fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

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

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

0330 - 144g.30 Subd. 4 - Information Provided By Facility - $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

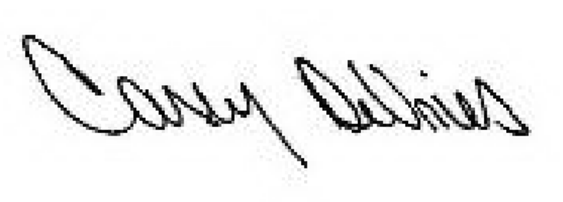
To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms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



Casey DeVries, Supervisor
State Evaluation Team
Email: casey.devries@state.mn.us
Telephone: 651-201-5917 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
	37713	A. BUILDING: _____ B. WING _____	07/16/2024

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0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL37713015-0 On July 15, 2024, through, July 16, 2024, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were three residents all of whom received services under the Assisted Living Facility 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 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.	
0 330 SS=F	144G.30 Subd. 4 Information provided by facility (a) The assisted living facility shall provide	0 330		

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0 330	Continued From page 1 accurate and truthful information to the department during a survey, investigation, or other licensing activities. (b) Upon request of a surveyor, assisted living facilities shall within a reasonable period of time provide a list of current and past residents and their legal representatives and designated representatives that includes addresses and telephone numbers and any other information requested about the services to residents. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide accurate and truthful employee record information during the survey for two of three employees (unlicensed personnel (ULP-A, ULP-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On July 15, 2024, at 9:52 a.m., during the entrance conference, licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated employee records were stored electronically and in paper format. LALD/CNS-C stated the employee records were located onsite at the licensee's facility were the survey occurred. From July 15, 2024, through July 16, 2024, the surveyor requested employee orientation	0 330		

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0 330	Continued From page 2 documents and discussed missing orientation documents within the employee records for ULP-A and ULP-B with LALD/CNS-C. On July 16, 2024, at 9:01 a.m., LALD/CNS-C stated, "it was a mistake" that they did not fill in the dates on the home care orientation for ULP-B. LALD/CNS-C stated when the licensee converted from their comprehensive license to their assisted living license, they held an in-person meeting and completed assisted living orientation with all employees. LALD/CNS-C stated ULP-B completed an in-person orientation for assisted living however, they were unable to locate the documentation. LALD/CNS-C stated they believed the orientation documents for ULP-A and ULP-B could be located in the offsite office. On July 16, 2024, at 1:29 p.m., the surveyor entered the second floor near the medication cart and observed housing manager (HM)-C on the computer with an EduCare (online training platform) guide open on the computer screen. The surveyor also observed LALD/CNS-C with a pen in hand and two sheets of paper. The top paper was visible and the surveyor observed an orientation check list with all required topics, ULP-B's name written on it, LALD/CNS-C's signature at the bottom, and a date of August 2023 written on the bottom. The paper did not have ULP-B's signature on it. The surveyor was unable to observe the second piece of paper before LALD/CNS-C put it away to go to the "office". The surveyor inquired why they had orientation checklist in hand. LALD/CNS-C stated they were filling out the papers to remind them of what they needed to find at the office. On July 16, 2024, at 1:53 p.m., the surveyor inquired again why they were filling out EduCare	0 330		

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0 330	Continued From page 3 orientation paperwork for ULP-B. LALD/CNS-C stated they were checking the computer and writing down if they had completed it. The surveyor inquired why they had backdated the form if they were just using it to gather information. LALD/CNS-C stated, "sometimes when I forget to do something you penalize me for it." No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 330		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents).	0 480		

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0 480	Continued From page 4 The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated July 16, 2024, 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		
0 630 SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for one of three residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	0 630		

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DIS-GENERATION GROUP INC	9032 PRESTWICK PARKWAY BROOKLYN CENTER, MN 55443

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0 630	Continued From page 5 resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 admitted to the licensee on February 5, 2023, and began receiving assisted living services. R1's Service Plan (Waiver) - Addendum to Contract signed February 9, 2024, indicated R1 received assistance with diabetic management that included a blood sugar sensor, housekeeping, laundry, meals, medication administration, and shopping. R1's Individual Abuse Prevention Plan dated February 16, 2024, indicated R1 was not at risk to abuse other vulnerable adults. R1's record lacked an individualized review or assessment of R1's susceptibility to be abused by another individual. On July 16, 2024, at 9:19 a.m., the surveyor observed licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C open RTasks (a documenting software program) and observed two statements that indicated if R1 was or was not at risk to be abused by others was not marked off. LALD/CNS-C then placed a mark next to the statement that he was not at risk to be abused. LALD/CNS-C stated R1 was cognitively alert. LALD/CNS-C stated they normally mark statements in the IAPP that need an intervention and they missed marking the statement that applied to R1 susceptibility to abuse. The licensee's 6.05 Individual Abuse Prevention	0 630		

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0 630	Continued From page 6 Plan dated July 26, 2021, indicated the IAPP would 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. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 650 SS=E	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place	0 650		

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0 650	Continued From page 7 and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the employee record contained the required content for two of three employees (unlicensed personnel (ULP)-A, ULP-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: On July 15, 2024, at 9:52 a.m., during the entrance conference, licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated employee records were stored electronically and in paper format. LALD/CNS-C stated the employee records were located onsite at the facility being surveyed. ULP-A ULP-A began employment with the licensee on August 8, 2022, and began providing direct cares and services to residents. On July 16, 2024, at 8:02 a.m., the surveyor observed ULP-A administer oral medications to	0 650		

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0 650	Continued From page 8 R2. ULP-A's employee record lacked the following required orientation topics: - overview of assisted living statues; - handling resident complaints and reporting of complaints, where to report; - consumer advocacy services; and - review of assisted living services the employee would provide and the providers scope of license. On July 16, 2024, at 11:02 a.m., ULP-A stated they received the orientation listed above in person by LALD/CNS-C. ULP-B ULP-B began employment with the licensee on October 14, 2021, and began providing direct cares and services to the residents. On July 15, 2024, at 4:08 p.m., the surveyor observed ULP-B completing tasks in the kitchen. ULP-B's record included a home care orientation listed with the home care orientation regulations signed on the last page by LALD/CNS-C. The home care orientation topics had a column titled Date Provided-Orientation and were left blank with no markings. In addition, ULP-B's record in RTasks (a documenting software) included training on assisted living statues in 2022. ULP-B's record lacked the following required orientation topics: - review of provider's policy and procedures; - handling complaints, reporting of complaints, where to report complaints; - consumer advocacy services; and - review of types of assisted living services the employee would provide and providers scope of license.	0 650		

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0 650	Continued From page 9 On July 16, 2024, at 10:23 a.m., the surveyor attempted to contact ULP-B for an interview. The surveyor did not receive a call back prior to the end of the survey. On July 16, 2024, at 9:01 a.m., LALD/CNS-C stated, "it was a mistake" that they did not fill in the dates on the home care orientation for ULP-B. LALD/CNS-C stated when the licensee converted from their comprehensive license to their assisted living license, they held an in-person meeting and completed assisted living orientation with all employees. LALD/CNS-C stated ULP-B completed an in-person orientation for assisted living however, they were unable to locate the documentation. LALD/CNS-C stated they believed the orientation documents for ULP-A and ULP-B could be located in the offsite office. The surveyor declined to accept further documentation related to ULP-A and ULP-B's orientation after the interview noted above because the surveyor observed LALD/CNS-C completing an orientation document while on-site at the facility and backdating the orientation check list on July 16, 2024, at 1:29 p.m. The licensee's 4.05 Employee Records policy dated July 26, 2021, indicated the employee record for each person would include record of all training and in-service education required and/or provided including record of competency testing as required. The licensee's 5.01 Orientation of Staff and Supervisors & Content policy dated July 26, 2021, read, "3. The orientation must contain the following topics: o An overview of the appropriate Assisted Living	0 650		

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0 650	Continued From page 10 statutes and rules o An introduction and review of the facility's policies and procedures related to the o provision of assisted living services by the individual staff person o Handling of emergencies and use of emergency services o Compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC) o The assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights o Principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person o Handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints o 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 o A review of the types of assisted living services the employee will be providing and the facility's category of licensure o The staff person's job description upon hire and whenever there is a change to the job description that changes the nature of the job or how the job is to be performed o The facility's organization chart and the roles of staff within the facility, and the services offered by the facility as identified in the uniform checklist disclosure of services o The identification of incidents of maltreatment	0 650		

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0 650	Continued From page 11 as defined under Minnesota Statutes, section 626.5572, subdivision 15, including abuse, financial exploitation, and neglect, and an explanation that any act that constitutes maltreatment is prohibited." 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; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule.	0 680		

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0 680	Continued From page 12 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a written emergency preparedness plan (EPP) with all the required content as defined in Appendix Z. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's emergency disaster preparedness plan lacked evidence of the following required content: - annual update; - consider emerging infectious diseases; - hazard vulnerability risk assessment; - strategies for addressing facility and community-based risk to include staffing surges or shortages and back- up plans; - quarterly review of missing resident policy; - process for emergency plan (EP) collaboration; - subsistence needs for staff and residents to include sewage and waste disposal; - policies for evacuation to include transportation, identification of primary and alternative evacuation locations; - policies and procedures for volunteers; - arrangement with other facilities; - names and contact information;	0 680		

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0 680	Continued From page 13 - emergency officials contact information; - long term care family notifications; and - emergency prep testing requirements. On July 16, 2024, at 1:37 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated if there was an emergency, they would bring the residents to a local hotel. LALD/CNS-C was unable to tell the surveyor the name of the hotel. LALD/CNS-C stated they did not have a written agreement with the hotel because they wanted to charge the licensee a fee even if the licensee never activated their EPP. Housing manager (HM)-E stated they would use the company car to transport residents in a case of an emergency however, they did not have documentation of this in the EPP. LALD/CNS-C stated they reviewed the EPP annually and when the EPP was reviewed they would reprint the EPP. LALD/CNS-C stated they did not know how to print off or find the dates reviewed in RTasks (a documenting software). LALD/CNS-C stated they reviewed the missing resident policy annually and were unaware of the requirement to review it quarterly. HM-E stated the licensee did not complete a hazard vulnerability assessment. LALD/CNS-C stated they do not have a plan for staffing shortages because agencies were too expensive, and they have never had to use one. The licensee's 9.01 Emergency Preparedness Plan - Appendix Z Compliance dated October 15, 2021, indicated the licensee had in place and effective and compliant EPP. The EPP would be aligned with the Centers for Medicare and Medicaid Services State Operation Manual Appendix Z. No further information was provided.	0 680		

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0 680	Continued From page 14 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
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 of the facility in a continuous state of good repair and operation. This has the potential to directly affect the health, safety, and well-being of the resident in sleeping room 2 in the lower-level floor. 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: On July 16, 2024, approximately from 10:30 a.m. to noon, survey staff toured the home with housing manager (HM)-E. During the tour, survey	0 800		

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0 800	Continued From page 15 staff observed resident sleeping room 2 door had a hasp door hardware on the hallway side that can be locked in the means of egress if a padlock is installed that restricts exiting from inside the room. Survey staff explained that any accidental locking of the door could restrict egress for the resident from the inside during an emergency. HM-E verified the finding at the time of discovery and stated that HM-E will remove talk to the resident (room 2) and remove the hasp hardware. On July 16, 2024, at approximately 12:30 p.m., at the exit interview, licensed assisted living director/clinical nurse supervisor (LALD/CMS)-C and HM-E understood and acknowledged the above finding. LALD/CMS-C stated that if they knew, they would of easily unscrew the hardware before the finding. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique	0 810		

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0 810	Continued From page 16 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, document review, and interview, the licensee failed to provide all required contents on the fire safety and evacuation plan, the minimum number of fire evacuation drills, and the required minimum training of staff and residents on the fire safety and evacuation plan. This has the potential to directly affect the safety of visitors, staff, and all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected	0 810		

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0 810	Continued From page 17 or has the potential to affect a large portion or all of the residents). The findings include: On July 16, 2024, from 10:30 a.m. to noon, survey staff toured the home with housing manager (HM)-E. During the tour, survey staff observed the following: -The posted evacuation floor plan in the basement level did not include resident sleeping room 5. HM-E concurred with the finding at the time of discovery as he looked closer at the plan. HM-E explained the bedroom was recently added but they had not updated the posted floor plan. -A discrepancy in the resident sleeping rooms numbering between the evacuation floor plan and the labeling on the room doors. The posted home layout plan room numbers differed from the actual labeling of the room numbers on the doors. On July 16, 2024, at approximately 12:30 p.m. document review and interview with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C and HM-E indicated the following: -The emergency preparedness binder had multiple employee fire safety procedures which can confuse training and during an emergency. LALD/CNS-C verified the finding and stated that the penciled lining fire procedure was the procedure that was no longer valid. Survey staff indicated that they review and remove all outdated procedures in the binder. -The plan was incomplete. Home address, designated emergency resident relocation information, and safe place to meet outside after	0 810		

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0 810	Continued From page 18 an emergency evacuation were not included and/or filled out. Survey staff explained to both LALD/CNS-C and HM-E, and both agreed that the plan lacked the information for clarity during an emergency. -The plan documentation lacked fire protection procedures for residents. -The policy documentation lacked the records of employee training on the facility fire safety and evacuation plan at least twice per year after new hire orientation. The only record available for review was a list of employees and each signed the employee acknowledgment documentation for the documentation titled, Emergency Preparedness Plan and Procedures. The list did not include any employee signed for at least training on two separate dates for the calendar year 2023. - No documentation was available or provided for review on fire evacuation drills for the calendar year 2023. On July 16, 2024, at approximately 12:30 p.m., LALD/CNS-C and HM-E understood and acknowledged the above findings during the interview. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 820 SS=D	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including	0 820		

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0 820	Continued From page 19 assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure physical facility elements did not constitute a distinct hazard to life. The licensee failed to provide the minimum state standard-sized egress windows for unoccupied resident sleeping room 3. This had the potential to affect unoccupied resident in room 3. 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: On July 16, 2024, from 10:30 a.m. to noon, survey staff toured the home with housing manager (HM)-E. In the unoccupied bedroom 3 on the upper level, survey staff measured the clear openings of the two double-hung egress windows, and neither met the minimum total clear area of 648 square inches opening size required for safe egress in sleeping rooms. Both windows	0 820		

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	37713	A. BUILDING: _____ B. WING _____	07/16/2024

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0 820	Continued From page 20 were measured with dimensions, height at 23 inches and width at 24.5 inches, totaling an area for each window with a clear opening size of 563.5 inches, which did not meet the required minimum total clear window opening area of 648 inches. Survey staff noted that sleeping room 3 was the only sleeping room with double hung type windows in the home and explained to HM-E that at least one of the two windows must have the required state standard minimum total clear opening area of 648 inches (4.5 square feet) in a resident sleeping room for existing sleeping rooms in assisted living homes. The above finding was verbally verified with HM-E accompanying the tour. HM-E stated they recently received an email or information on window sizes and replaced the two windows (sleeping room 3). On July 16, 2024, at approximately 12:30 p.m., survey staff explained the sleeping room must not be occupied until the deficiency is corrected with complying egress window. Licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C and HM-E understood and acknowledged the above finding. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 820		
01060 SS=D	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of	01060		

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01060	Continued From page 21 another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and	01060		

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01060	Continued From page 22 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation to the resident, legal representative, or designated representative and failed to provide the notification to the Office of Ombudsman for Long-Term Care (OOLTC) of the emergency relocation greater than four days for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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 admitted to the licensee on November 11, 2023, and began receiving assisted living services. R2's Service Plan (Waiver)-Addendum to Contract signed on February 21, 2024, indicated R2 received assistance with activities, exercise, bathing twice per week, dressing, grooming, housekeeping, laundry, meals, medication administration, shopping, and socialization. R2's progress notes dated December 27, 2023, through February 20, 2024, indicated R2 was sent to the hospital on January 7, 2024, due to behaviors and returned to the licensee's facility on February 16, 2024.	01060		

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01060	Continued From page 23 R2's record lacked evidence the licensee provided the resident or resident's representative a written emergency relocation notice. The record also lacked evidence to indicate the licensee provided the notification to the OOLTC of the emergency relocation greater than four days as required. On July 16, 2024, at 9:40 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated they did not provide R2 with an emergency relocation notice and they did not notify OOLTC of the emergency relocation. LALD/CNS-C stated recently learned about the requirement through a Minnesota Department of Health (MDH) survey completed at a sister facility. LALD/CNS-C stated R2 was the only resident who had an emergency relocation at the facility. The licensee's 1.23 Emergency Relocation policy dated July 26, 2021, indicated in the event of an emergency relocation, the licensee would provide a written notice that contained at a minimum: - the reason for relocation; - the name and contact information for the location to which the resident has been relocated and any new service provider; - contact information for OOLTC; - if know and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and - a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal. The licensee would deliver the notice as soon as practicable to the resident, legal representative, and designated representative. In addition,	01060		

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01060	Continued From page 24 OOLTC would receive the notice if the resident has been relocated and has not returned to the facility within four days. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
01530 SS=D	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter;	01530		

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01530	Continued From page 25 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure direct care employees received at least two hours training on topics related to dementia care for each 12 months of employment for one of three unlicensed personnel ((ULP)-A). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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: ULP-A began employment with the licensee on August 8, 2022, and began providing direct cares and services to residents. On July 16, 2024, at 8:02 a.m., the surveyor observed ULP-A administer oral medications to R2. ULP-A's EduCare (training software) transcript included 1.75 hours of dementia care training for 2023, however lacked two hours of dementia care training for each twelve months of employment. On July 16, 2024, at 9:16 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated ULP-A was missing 15 minutes of dementia care training. LALD/CNS-C stated they missed assigning one of the dementia care training courses in EduCare to ULP-A.	01530		

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01530	Continued From page 26 The licensee's 5.03 Dementia Training policy dated July 17, 2024, indicated all staff would complete two hours of additional training related to dementia for each 12 months of work. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
01560 SS=D	144G.64 (a, b, c) TRAINING IN DEMENTIA CARE REQUIRED (5) new employees may satisfy the initial training requirements by producing written proof of previously completed required training within the past 18 months. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and other dementias; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; (4) communication skills; and (5) person-centered planning and service delivery. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to dementia care training on the required topics for one of three unlicensed personnel ((ULP)-B).	01560		

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01560	Continued From page 27 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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: ULP-B began employment with the licensee on October 14, 2021, and began providing direct cares and services to the residents. On July 15, 2024, at 4:08 p.m., the surveyor observed ULP-B completing tasks in the kitchen. ULP-B's record included an EduCare (a training software) transcript which included the following topics: dementia balanced approach, dementia activities of bathing, exercise, and nutrition, dementia communication overview, dementia overview, dementia communication overview, and dementia problem solving overview, anxiety, sleep, use of medication, sundowning, anger, and wandering. ULP-B's record lacked the required topic of dementia person-centered planning and service delivery. On July 16, 2024, at 9:01 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C verified ULP-B's record lacked the required topic of dementia person-centered planning and service delivery. LALD/CNS-C stated the course from EduCare did not populate for ULP-B to complete. The licensee's 5.03 Dementia Training policy	01560		

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01560	Continued From page 28 dated July 17, 2024, indicated required dementia training topics included: - an explanation of Alzheimer's disease and other dementias; - assistance with activities of daily living; - problem solving with challenging behaviors; - communication skills; and - person centered planning and service delivery. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01560		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must 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	01620		

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01620	Continued From page 29 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) completed ongoing resident reassessments that did not exceed 90 days for three of three residents (R1, R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On July 15, 2024, at approximately 9:52 a.m., during the entrance conference, licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated the licensee completed a preadmission assessment, admission assessment, 14-day assessment, 90-day assessments, and change of condition assessments. R1 R1 admitted to the licensee on February 5, 2023, and began receiving assisted living services. R1's Service Plan (Waiver) - Addendum to Contract signed February 9, 2024, indicated R1 received assistance with diabetic management that included a blood sugar sensor, housekeeping, laundry, meals, medication	01620		

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01620	Continued From page 30 administration, and shopping. R1's record included an ongoing 90-day assessment completed on February 16, 2024, and did not include other assessments completed after that date. As of July 16, 2024, 151 days had passed since the last ongoing assessment for R1. On July 16, 2024, at 9:23 a.m., LALD/CNS-C stated R1's assessment was supposed to be completed in May 2024. LALD/CNS-C stated they believed they clicked the wrong button when they closed the assessment and because of that it did not set a reminder to complete the assessment and did not populate a new assessment in RTasks (a documenting software). R2 R2 admitted to the licensee on November 11, 2023, and began receiving assisted living services. R2's Service Plan (Waiver)-Addendum to Contract signed on February 21, 2024, indicated R2 received assistance with activities, exercise, bathing twice per week, dressing, grooming, housekeeping, laundry, meals, medication administration, shopping, and socialization. R2's record included an ongoing 90-day assessment completed on February 16, 2024, and did not include other assessments completed after that date. As of July 16, 2024, 151 days had passed since the last ongoing assessment for R2. On July 16, 2024, at 9:41 a.m., LALD/CNS-C stated they did not close the last assessment completed correctly in order for RTasks to	01620		

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01620	Continued From page 31 repopulate the next ongoing assessment. LALD/CNS-C stated, "so it was missed." R3 R3 admitted to the licensee on September 25, 2019, under the licensee's former comprehensive license and began receiving assisted living services on August 1, 2021. R3's Service Plan (Waiver) - Addendum to Contract signed February 9, 2024, indicated R3 received assistance with activities, exercise, bathing, personal possession assist, continence care and toileting reminders, dressing, grooming, housekeeping, laundry, meals, medication administration, shopping, and socialization. R3's record included ongoing 90-day assessments completed on November 5, 2023, and February 4, 2024, which indicated 91 days had passed between assessments. On July 16, 2024, at 9:45 a.m., LALD/CNS-C stated they shifted R3's assessment to be completed prior to the weekend and they thought they had scheduled the assessment to fall within the 90 days. The licensee's 6.01 Assessments, Reviews, & Monitoring policy dated July 26, 2021, indicated 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. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		

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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. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed	01730		

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01730	Continued From page 33 when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and maintain a current individualized medication management record for each resident to include all required content for three of three residents (R1, R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 R1 admitted to the licensee on February 5, 2023, and began receiving assisted living services. R1's Service Plan (Waiver) - Addendum to Contract signed February 9, 2024, indicated R1 received assistance with diabetic management that included a blood sugar sensor, housekeeping, laundry, meals, medication administration, and shopping. R1's Med Admin Summary - Month dated July 2024, indicated R1 received ten scheduled medications from 8:00 a.m. to 8:00 p.m. R1's Individualized Medication Management Plan	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37713	A. BUILDING: _____ B. WING _____	07/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIS-GENERATION GROUP INC	9032 PRESTWICK PARKWAY BROOKLYN CENTER, 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
01730	Continued From page 34 dated February 16, 2024, indicated R1's medications were stored by the licensee, R1 needed full medication management, unlicensed personnel (ULP) were delegated to administer inhalers, eye drops, and oral medications, and ULP were to contact the registered nurse by phone if there were any questions or concerns with medications. R2 R2 admitted to the licensee on November 11, 2023, and began receiving assisted living services. R2's Service Plan (Waiver)-Addendum to Contract signed on February 21, 2024, indicated R2 received assistance with activities, exercise, bathing twice per week, dressing, grooming, housekeeping, laundry, meals, medication administration, shopping, and socialization. On July 16, 2024, at 8:02 a.m., the surveyor observed ULP-A administer oral medications to R2. R2's Med Admin Summary - Month dated July 2024, indicated R2 received nine schedule medications between 8:00 a.m. and 7:00 p.m. R2's Individualized Medication Management Plan dated February 16, 2024, indicated staff administer R2's medications, the licensee stored R2's medications, ULP were delegated oral and topical medications, and staff could call the nurse 24 hours per day for questions or concerns related to medications. R3 R3 admitted to the licensee on September 25, 2019, under the licensee's former comprehensive	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37713	A. BUILDING: _____ B. WING _____	07/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIS-GENERATION GROUP INC	9032 PRESTWICK PARKWAY BROOKLYN CENTER, 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
01730	Continued From page 35 license and began receiving assisted living services on August 1, 2021. R3's Service Plan (Waiver) - Addendum to Contract signed February 9, 2024, indicated R3 received assistance with activities, exercise, bathing, personal possession assist, continence care and toileting reminders, dressing, grooming, housekeeping, laundry, meals, medication administration, shopping, and socialization. R3's Med Admin Summary - Month dated July 2024, indicated R3 received ten medications at 8:05 p.m. R3's Individualized Medication Management Plan dated May 3, 2024, indicated medications were administered to R3 by staff, R3 preferred to take his medication with water, R3's medications were stored in the medication cabinet, ULP were delegated to administer inhalers and oral medications, and ULP could contact a nurse by phone for any questions or concerns related to medications. R1, R2, and R3's individual medication management plans comprised of multiple documents lacked the following required content: - identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis. On July 16, 2024, at 9:42 a.m., LALD/CNS-C stated they were unaware of why they did not mark in the RTasks (a documenting software program) that the RN monitored medication supplies and were responsible for refills for R2 and R3. On July 17, 2024, at 9:25 a.m., licensed assisted	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37713	A. BUILDING: _____ B. WING _____	07/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIS-GENERATION GROUP INC	9032 PRESTWICK PARKWAY BROOKLYN CENTER, MN 55443

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01730	Continued From page 36 living director/clinical nurse supervisor (LALD/CNS)-C stated they were responsible for monitoring medication supplies and reordering medications. LALD/CNS-C stated they were aware of the required content of the individualized medication management plan. LALD/CNS-C stated R1 used to pick up some of their medications until they turned 65 due to insurance not covering the over-the-counter medications. LALD/CNS-C stated after R1 turned 65 the licensee provided all medications, and they did not go back into the medication management plan to update it. The licensee's 7.03 Medication Management Individualized Plan policy dated July 26, 2021, read, "[the licensee] will develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: a .A statement describing the medication management services that will be provided b. A description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions c. Documentation of specific resident instructions relating to the administration of medications d. Identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis e. Identification of medication management tasks that may be delegated to unlicensed personnel f. Procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services, and g. Any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37713	A. BUILDING: _____ B. WING _____	07/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIS-GENERATION GROUP INC	9032 PRESTWICK PARKWAY BROOKLYN CENTER, MN 55443

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01730	Continued From page 37 as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to discard expired medication for one of three residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On July 15, 2024, at approximately 10:30 a.m., during a facility tour, the surveyor observed the	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37713	A. BUILDING: _____ B. WING _____	07/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01890	Continued From page 38 secured medication cart and observed R3's hydroxyzine 25 mg blister card with an expiration date of August 9, 2023. On July 15, 2024, at 10:38 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated when medications were expired in the medication cart, they disposed of the medication by taking the medication to Walgreens. LALD/CNS-C stated they audited the cart once a month for expired medications. The surveyor inquired why the medication listed above was not disposed of. LALD/CNS-C stated they believed R3 no longer used the medication, and they would dispose the medication. The surveyor than observed LALD/CNS-C take the medication out of the cart and stated they were going to take it to their office. The licensee's Medication Disposition or Disposal policy dated October 1, 2021, indicated unused or discontinued prescription drugs managed by the licensee would be destroyed by sending the medications to Hennepin County transfer station within one month or less of the time they are discontinued. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		

Minnesota Department of Health
Environmental Health, FPLS
P.O. Box 64975
St. Paul, MN 55164-0975
6512014500

Type: Full
Date: *07/16/24*
Time: 10:00:00
Report: 1047241169

Food and Beverage Establishment Inspection Report

Location:
Dis-Generation Group Inc
9032 Prestwick Parkway
Brooklyn Park, MN55443
Hennepin County, 27

Establishment Info:
ID #: 0038472
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7632050467
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.

4-700 Sanitizing Equipment and Utensils

4-703.11B ***** Priority 1 *****

MN Rule 4626.0905B Sanitize food contact surfaces of equipment and utensils after cleaning by using mechanical hot water operations that achieve a utensil surface temperature of 160 degrees F (71 degrees C) and are set up and maintained in accordance with the specifications of NSF International and the manufacturer's data plate.

DISHWASHER DID NOT REACH 160F ON THE TEMPERATURE TEST STRIP. FACILITY STATED THEY WILL RUN ANOTHER TEST STRIP THROUGH THE MACHINE TO VERIFY TEMPERATURE. ALTERNATE SANITIZATION METHODS WILL NEED TO BE IMPLEMENTED IF DISHWASHER IS NOT REACHING 160F.

Comply By: 07/18/24

2-100 Supervision

2-102.12AMN

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

NO STATE CERTIFIED FOOD PROTECTION MANAGER. OPERATOR STATED THEIR CERTIFICATE HAD EXPIRED & THEY WILL NEED TO RESUBMIT EVERYTHING TO THE STATE.

Comply By: 08/16/24

Surface and Equipment Sanitizers

Hot Water: = at Degrees Fahrenheit
Location: Dishmachine
Violation Issued: No

Food and Equipment Temperatures

Type: Full
Date: *07/16/24*
Time: 10:00:00
Report: 1047241169
Dis-Generation Group Inc

Food and Beverage Establishment Inspection Report

Process/Item: Cold Holding
Temperature: 38 Degrees Fahrenheit - Location: Refrigerator- Cottage cheese
Violation Issued: No

Process/Item: Cold Holding
Temperature: 26 Degrees Fahrenheit - Location: Refrigerator- chicken
Violation Issued: No

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

The inspection was conducted with the operator & MDH nurse evaluator A. Crews.

The establishment has a residential kitchen & serves food that is prepared that day. The kitchen has wood cabinets, laminate floor, painted ceiling & walls, and a solid countertop.

A two basin sink is located in the kitchen. One sink basin is designated for hand washing. A residential dish machine is located in the kitchen.

Discussed hand washing, ware washing, staff illness policy, temperature control, final cook temperatures, cleaning, serving highly susceptible populations, & food handling procedures.

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 1047241169 of 07/16/24.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /

Inspection report reviewed with person in charge and emailed.

Signed:_____

Stella Iwuckukwu
Operator

Signed:_____

Holly Sievers
Public Health Sanitarian 2
Metro Office
6512015946
Holly.Sievers@state.mn.us