Electronically Delivered

December 31, 2024

Licensee
The Moments of Lakeville
16258 Kenyon Avenue
Lakeville, MN 55044

RE: Project Number(s) SL33524016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on November 21, 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.

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 . . ."

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

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.

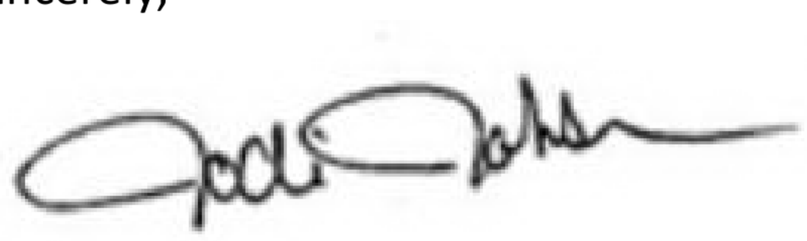
To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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,



Jodi Johnson, Supervisor
State Evaluation Team
Email: Jodi.Johnson@state.mn.us
Telephone: 507-344-2730 Fax: 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
	33524	A. BUILDING: _____ B. WING _____	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MOMENTS OF LAKEVILLE	16258 KENYON AVENUE LAKEVILLE, MN 55044

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0 000	Initial Comments 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: SL33524016-0 On November 18, 2024, through November 21, 2024, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 83 residents; 83 receiving services under the Assisted Living Facility with Dementia Care 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.	
0 480 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, 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: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated November 19, 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	0 480		

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0 480	Continued From page 3 to the FBEIR for any compliance dates.	0 480		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post in a conspicuous place, the name and email contact information for the individuals responsible for handling resident grievances. This had the potential to affect the licensee's current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems	0 550		

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0 550	Continued From page 4 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 November 18, 2024, at 2:25 p.m., the surveyor toured the facility and observed the posted grievance procedure near the front entrance. The procedure included the title and telephone number for the individual responsible for handling grievances, but it lacked the name and email contact information. On November 18, 2024, at 4:00 p.m., business office manager (BOM)-C stated the form lacked the name and email contact information and was not aware it needed to be included. The licensee's 2.10 Complaint/Grievance Posting policy dated August 1, 2021, included: 1. [The Licensee] will post, in a conspicuous place, information about our complaint/grievance procedure, and the name, telephone number, and email contact information for the individual(s) who are responsible for handling resident complaint/grievances. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 550		
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	0 680		

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0 680	Continued From page 5 contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post an emergency disaster plan prominently, provide residents with exit diagrams, have a written emergency preparedness (EP) plan with all the required content, and practice and document testing of it's EP plan at least twice annually as required. This had the potential to affect all residents, staff, and visitors of the facility. 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	0 680		

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0 680	Continued From page 6 or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: POST AN EMERGENCY DISASTER PLAN PROMINENTLY During the facility tour on November 18, 2024, at 2:25 p.m., the surveyor observed there was no signage posted, or information regarding the licensee's EP plan. On November 18, 2024, at 4:05 p.m., business office manager (BOM)-C stated the EP book was kept behind the reception desk and the plan was not posted within the facility. BOM-C further indicated she was not aware of the requirement. PROVIDE BUILDING EMERGENCY EXIT DIAGRAMS TO ALL RESIDENTS During the initial tour on November 18, 2024, at 2:25 p.m., the surveyor observed there was no signage on the inside of the resident doors or inside the licensee's admission packet with emergency exit diagrams. On November 18, 2024, at 4:05 p.m., BOM-C stated emergency exit diagrams were not provided to residents, but diagrams were posted on the wall on each floor. BOM-C indicated she was not aware of the requirement. EMERGENCY PREPAREDNESS PLAN CONTENT The licensee's EP plan consisted of a risk assessment, communication plan, various policies/procedures and documents dated as	0 680		

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0 680	Continued From page 7 reviewed August 31, 2024. The licensee lacked a customized EP plan to include the following required content: - Development of all policies/procedures, based on assessment, and an additional policy for: - Policy/procedure for sheltering in place. On November 21, 2024, at 11:16 a.m., BOM-C stated the licensee's EP plan lacked the above required components. BOM-C indicated there were more policies on the licensed assisted living director's computer, but she did not have access to them and they were not included in the EP book. TESTING OF EP PLAN The licensee's EP plan contained documentation of a tabletop exercise completed September 12, 2023, titled "Should I Stay or Should I go". The EP plan lacked evidence the facility had tested it's EP plan, conducted and/or participated in a full-scale community-based exercise, or conducted a tabletop exercise to test it's plan and document the results of testing at least twice annually as required. On November 21, 2024, at 11:16 a.m., BOM-C stated the licensee's EP plan lacked the above required component stating there was only documentation (greater than one year ago) of the one tabletop as noted above. The licensee's 4.01 Training, Exercises, and Testing policy revised April 25, 2023, noted annually, staff would participate in a full-scale exercise that is community-based, or when a community-based exercise is not accessible, an	0 680		

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0 680	Continued From page 8 individual, facility based tabletop exercise. If a community-based full-scale exercise is not available, the facility will document their attempts to participate in one and replace it with a table-top exercise. If the facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the facility is exempt from engaging in a community-based or individual, facility-based full-scale exercise for one year following the onset of the actual event. The facility will also conduct an additional annual exercise that may include, but is not limited to the following: -A second full-scale exercise that is community-based or individual, facility-based; -A tabletop exercise that includes a group discussion led by a facilitator, using a narrated clinically relevant emergency scenario, and a set of problem statements directed to challenge the emergency plan; or -A mock disaster drill Per Assisted Living Facilities: Minnesota Rules Chapter 4695, 4659.0100, sections A and B, assisted living facilities shall comply with the federal emergency preparedness regulations for long-term care facilities under Code of Federal Regulations, title 42, section 483.73, or successor requirements. This part references documents, specifications, methods, and standards in "State Operations Manual Appendix Z - Emergency Preparedness for All Providers and Certified Supplier Types: Interpretive Guidance," which is incorporated by reference. Per Assisted Living Facilities: Minnesota Rules Chapter 4659, 4659.0110, Subp. 4. Review missing resident plan. The assisted living director and clinical nurse supervisor must review the missing person plan at least quarterly and	0 680		

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0 680	Continued From page 9 document any changes to the plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
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	0 810		

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0 810	Continued From page 10 required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to conduct the required training and drills. 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 November 19, 2024, at 4:05 p.m., business office manager (BOM)-C provided documentation on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. DRILLS Record review indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month. Documentation provided showed that drills were conducted August 26, 2024, and October 4, 2024. These were the only drills conducted in 2024. During interview on November 19, 2024, at 4:35 p.m., BOM-C stated that only two drills had been	0 810		

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0 810	Continued From page 11 conducted. BOM-C stated that they understood the requirements. TRAINING Record review indicated the licensee failed to provide evacuation training based on the fire safety and evacuation plan to employees, at hire and twice per year as evident by not providing documentation of training offered or training scheduled for a future date. During interview on November 19, 2024, at 4:35 p.m., BOM-C stated that they train the nurses because they are the point people. BOM-C stated that the nurses have been trained once in 2024 but no other employees are offered training on the fire safety and evacuation plan. The surveyor explained the requirement for training employees and BOM-C stated they understood the requirement. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by:	0 970		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 970	Continued From page 12 Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the licensee's liability for health, safety, or personal property of a resident. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: R1's Resident Agreement (identified as the contract) dated September 8, 2023, R2's Resident Agreement dated October 10, 2023, R3's Resident Agreement dated August 2, 2023, and R4's Resident Agreement dated February 29, 2024, included the following clause: -Page 7, section 5.5 of the contract indicated: "Indemnity. Resident shall indemnify, defend, and hold harmless Community, its officers, directors, shareholders, affiliates, employees and agents for (i) any loss, property damage, or cost of repair or service caused by the negligence or improper use by Resident, his/her agents, family or guests; or (ii) any injury to persons or property of others caused by the negligent, reckless, or intentional act or omission of Resident or Resident's guests. This indemnification includes costs for property damage to the Residence, the remainder of the Community property, and property of third parties, and shall not be limited by the amount of Resident's security deposit, if any."	0 970		

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	33524	A. BUILDING: _____ B. WING _____	11/21/2024

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0 970	Continued From page 13 On November 20, 2024, at 2:01 p.m., business office manager (BOM)-C reviewed the licensee's current contract and stated it included the above content. BOM-C stated this contract was utilized for all residents at the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact	01060		

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01060	Continued From page 14 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 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 for one of one hospitalized resident (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 the residents). The findings include: R3 began receiving assisted living services on August 2, 2023. R3's unsigned, Service Plan dated November 9,	01060		

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01060	Continued From page 15 2024, indicated R3 received services including bathing, dressing, hygiene/oral care, reminders for toileting, stand-by-assistance for transfers and ambulation, blood sugar management, and medication administration. R3's Progress Notes dated November 2, 2024, at 11:36 a.m. indicated R3 was taken to the emergency room by family for weakness/increased confusion, diarrhea, and swollen ear canal. Progress Notes dated November 5, 2024, at 1:12 p.m., identified R3 returned to the facility following the hospitalization. R3's record lacked a written notice that contained, at a minimum: - the reason for the relocation. - the name and contact information for the location to which the resident has been relocated and any new service provider. - contact information for the Office of Ombudsman for Long-Term Care. - 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. - 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. On November 20, 2024, at 9:29 a.m., clinical nurse supervisor (CNS)-B stated no written notice was provided to R3, or any residents that had been emergently relocated. In addition, CNS-B further stated the OOLTC had not been notified if residents had not returned to the facility within	01060		

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01060	Continued From page 16 four days. CNS-B stated she was not aware of the emergent relocation regulation. The licensee's 1.23 Emergency Relocation policy dated August 1, 2021, noted: In the event of an emergency relocation, [The Licensee] will provide a written notice that contains, at a minimum: a. The reason for the relocation; b. The name and contact information for the location to which the resident has been relocated and any new service provider; c. Contact information for the Office of Ombudsman for Long-Term Care; d. 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 e. A statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal. The facility will provide contact information for the agency to which the resident may submit an appeal. The notice required will be delivered as soon as practicable to: a. The resident, legal representative, and designated representative; b. For resident's who receive home and community-based waiver services, the resident's case manager; and c. The Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. No further information was provided. TIME PERIOD TO CORRECT: Twenty-one (21) days	01060		

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01290	Continued From page 17	01290		
01290 SS=D	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a background study was submitted and received in affiliation with the assisted living license health facility identification number (HFID) for one of two employees (unlicensed personnel (ULP)-H). 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).	01290		

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01290	Continued From page 18 The findings include: ULP-H began providing assisted living services on March 15, 2022. ULP-H's employee record contained a Background Study Clearance form dated August 3, 2022, for HFID 33360 (a separate license previously operated by the licensee's owner). ULP-H's employee record lacked evidence the licensee affiliated a background study for their current assisted living license HFID 33524. On November 21, 2024, at 8:23 a.m., business office manager (BOM)-C stated ULP-H's background study had not been affiliated with the assisted living facility license HFID. The licensee's 4.02 Background Studies policy dated August 1, 2021, noted the licensee would initiate a background study on all employees being considered for hire. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01500 SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557;	01500		

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01500	Continued From page 19 (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations,	01500		

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01500	Continued From page 20 isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure annual training included all required topics for each 12 months of employment for one of one employee (unlicensed personnel (ULP)-H). 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: ULP-H began providing assisted living services on March 15, 2022. ULP-H's employee record lacked documented evidence of the following required annual training: - review of provider's policies and procedures. On November 21, 2024, at 11:39 a.m., business office manager (BOM)-C stated ULP-H's employee record did not have evidence of the annual training as noted above. BOM-C stated she had asked the licensee's on-line education	01500		

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01500	Continued From page 21 software program for the required annual training requirements, and they had not included this. BOM-C further stated none of the licensee's employees would have this annual training in their files. The licensee's 5.06 Annual Required Staff Training policy dated August 1, 2021, noted the following training elements must be included every 12 months to all staff who perform direct care services: 5. Review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500		
01620 SS=E	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	01620		

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01620	Continued From page 22 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 nurse completed ongoing resident reassessments that did not exceed 90 days for three of four residents (R1, R3, R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1 R1's diagnoses included dementia. R1's unsigned, service plan dated September 19, 2024, indicated R1 received assistance with bathing, dressing, personal hygiene/oral care, mobility in wheelchair, toileting, transfers, oxygen, thrombo-embolic deterrent (TED) hose (compression socks used to increase circulation	01620		

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01620	Continued From page 23 and reduce swelling in the legs), and medication management. R1's record included a Health and Service Evaluation assessment dated June 20, 2024, and September 19, 2024. The September 19, 2024, assessment was 91 days after the June 20, 2024, assessment, thus exceeding 90 calendar days. R3 R3's diagnoses included dementia and obstructive sleep apnea. R3's unsigned, service plan dated November 9, 2024, indicated R3 received services including bathing, dressing, hygiene/oral care, reminders for toileting, stand-by-assistance for transfers and ambulation, blood sugar management, and medication administration. R3's record included a Health and Service Evaluation assessment dated June 27, 2024, and September 26, 2024. The September 26, 2024, assessment was 91 days after the June 27, 2024, assessment, thus exceeding 90 calendar days. R4 R4's diagnoses included Alzheimer's disease and anxiety. R4's unsigned, service plan dated September 19, 2024, indicated R4 received services including bathing, reminders for dressing, cues/encouragement for food and fluid consumption, and medication management. R4's record included a Health and Service Evaluation assessment dated June 20, 2024, and September 19, 2024. The September 19, 2024, assessment was 91 days after the June 20, 2024,	01620		

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01620	Continued From page 24 assessment, thus exceeding 90 calendar days. On November 21, 2024, at 8:31 a.m., clinical nurse supervisor (CNS)-B stated R1, R3, and R4's assessments were greater than 90 days from the previous assessments as noted above. CNS-B stated there had been a change in the assessment form in June 2024, and the 90-day assessment due dates had been incorrectly scheduled during the set up. The licensee's 6.01 Assessments, Reviews & Monitoring policy dated August 1, 2021, noted 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. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman	01640		

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01640	Continued From page 25 for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a written service plan was signed and revised to reflect the current services provided for two of four residents (R3, R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R3 R3's diagnoses included dementia and obstructive sleep apnea. On November 19, 2024, at 8:21 a.m., the surveyor observed R3 lying in bed with a continuous positive airway pressure (CPAP) (machine to keep your airways open while you sleep) on bedside table. Unlicensed personnel (ULP)-D stated R3 wore the CPAP at night when	01640		

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01640	Continued From page 26 sleeping and the night staff removed and cleaned it every morning. R3's unsigned, Service Plan dated November 9, 2024, indicated R3 received services including bathing, dressing, hygiene/oral care, reminders for toileting, stand-by-assistance for transfers and ambulation, blood sugar management, and medication administration. The service plan failed to identify the treatment of CPAP assistance. R3's prescriber orders dated May 30, 2024, included to use CPAP at night. R3's task completion record dated November 7, 2024, through November 19, 2024, included documentation R3 had assistance with CPAP each night. R1 R1's diagnoses included dementia. On November 19, 2024, at 11:51 a.m., the surveyor observed R1 wearing bilateral thrombo-embolic deterrent (TED) hose (compression socks used to increase circulation and reduce swelling in the legs) while seated in a wheelchair at the dining room table. R1's unsigned, service plan dated September 19, 2024, indicated R1 received assistance with TED hose. R1's prescriber orders dated January 25, 2024, included TED hose apply to bilateral lower extremities, on every morning and off at bedtime for circulation. R1's task completion record dated November 7, 2024, through November 19, 2024, included	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33524	A. BUILDING: _____ B. WING _____	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MOMENTS OF LAKEVILLE	16258 KENYON AVENUE LAKEVILLE, MN 55044

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01640	Continued From page 27 documentation R1 had TED hose on in the morning and off at bedtime. On November 20, 2024, at 2:18 p.m., clinical nurse supervisor (CNS)-B stated R3's service plan lacked the treatment of CPAP assistance and R3 and R1's revised service plan had not been signed by the resident or licensee. CNS-B stated all services provided should be included on the service plan and was not sure why R3's CPAP assistance was missing. CNS-B further stated the licensee did not have the service plans signed. The licensee's 6.10 Service Plan Modifications policy dated August 1, 2021, noted when a change to the service plan occurs, the service plan must be amended in writing and signed by the resident or the resident's designated representative. The licensee's 7.05 Treatment & Therapy Management Plan policy dated August 1, 2021, noted each resident receiving management of ordered or prescribed treatments or therapy services, the facility will prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided,	01650		

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01650	Continued From page 28 the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a service plan included the required content for four of four residents (R1, R2, R3, R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when	01650		

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01650	Continued From page 29 problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 R1's diagnoses included dementia. R1's unsigned, service plan dated September 19, 2024, indicated R1 received assistance with bathing, dressing, personal hygiene/oral care, mobility in wheelchair, toileting, transfers, oxygen, thrombo-embolic deterrent (TED) hose (compression socks used to increase circulation and reduce swelling in the legs), and medication management. R2 R2's diagnoses included congestive heart failure (when the heart can't pump blood well enough and blood and fluids collect in your lungs and legs over time), localized edema (swelling), and amnesia (loss of memory). R2's unsigned, service plan dated September 26, 2024, indicated R2 received assistance with bathing, dressing, personal hygiene/oral care, wound care, TED hose, and medication management. R3 R3's diagnoses included dementia and obstructive sleep apnea. R3's unsigned, service plan dated November 9, 2024, indicated R3 received services including bathing, dressing, hygiene/oral care, reminders for toileting, stand-by-assistance for transfers and ambulation, blood sugar management, and	01650		

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01650	Continued From page 30 medication administration. R4 R4's diagnoses included Alzheimer's disease and anxiety. R4's unsigned, service plan dated September 19, 2024, indicated R4 received services including bathing, reminders for dressing, cues/encouragement for food and fluid consumption, and medication management. R1, R2, R3, and R4's service plans lacked the following content: - fees for services; - frequency of each service; - the schedule and methods of monitoring assessments of the resident; - the schedule and methods of monitoring staff providing services; and - a contingency plan that includes: - the action to be taken if the scheduled service cannot be provided; - information and a method to contact the facility; - the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and - the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. On November 20, 2024, at 2:12 p.m., business office manager (BOM)-C stated the service plan	01650		

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01650	Continued From page 31 lacked the required content and would need to build the requirement into their computerized software program. In addition, BOM-C stated the same service plan template was utilized for all residents. The licensee's 6.08 Service Plan policy dated August 1, 2021, noted the service plan would include: a. Fees for services to be provided; b. The frequency of each service to be provided; c. A schedule and method for the next planned assessment or monitoring; d. A schedule and method for the next planned monitoring of staff providing services; e. A contingency plan that includes: - Actions to take if scheduled services cannot be provided; - Information regarding how the resident can contact the licensee; - The names and contact information the resident wishes, if any, to have notified in an emergency or if there is a significant adverse change in the resident's condition; - Identification and contact information of who the resident has authorized, if any, to sign for the resident in an emergency; - How the facility will support documented resident health care directive decision, if any, including circumstances when emergency medical services are not to be summoned. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01650		
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan	01730		

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01730	Continued From page 32 (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 when a licensed nurse, licensed health	01730		

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01730	Continued From page 33 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 implement a current individualized medication management plan to include all required content for four of four residents (R1, R2, R3, R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on November 18, 2024, at 11:20 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to residents at the facility. R1 R1's diagnoses included dementia. On November 19, 2024, at 12:50 p.m., the surveyor observed unlicensed personnel (ULP)-L administer medications to R1. R1's unsigned, service plan dated September 19, 2024, indicated R1 received assistance with medication management. R1's prescriber orders dated January 25, 2024,	01730		

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01730	Continued From page 34 included eye drops for dry eyes, three supplements, one for Parkinson's disease, one for urinary retention, one for anxiety, two for constipation, three vitamins, and one antipsychotic. R1's Medication Administration Record (MAR) dated November 1, 2024, through November 18, 2024, included medications as prescribed, times to administer, and staff initials to indicate the medications had been given. R2 R2's diagnoses included congestive heart failure (when the heart can't pump blood well enough and blood and fluids collect in your lungs and legs over time), localized edema (swelling), and amnesia (loss of memory). On November 19, 2024, at 8:56 a.m., the surveyor observed ULP-E administer medications to R2 in his room. R2's unsigned, service plan dated September 26, 2024, indicated R2 received assistance with medication management. R2's prescriber orders dated November 29, 2023, included one supplement, one for cholesterol, one for edema, one for depression, and one inhaler to increase air flow into the lungs. R2's MAR dated November 1, 2024, through November 18, 2024, included medications as prescribed, times to administer, and staff initials to indicate the medications had been given. R3 R3's diagnoses included dementia and obstructive sleep apnea.	01730		

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01730	Continued From page 35 On November 19, 2024, at 8:21 a.m., the surveyor observed ULP-D administer medications to R3 in his room. R3's unsigned, service plan dated November 9, 2024, indicated R3 received services including medication administration. R3's prescriber orders dated December 20, 2023, included two for blood pressure, one to prevent blood clots, two insulins, one for diabetes, one for depression, one for reflux, one for cholesterol, and four vitamins. R3's MAR dated November 1, 2024, through November 18, 2024, included medications as prescribed, times to administer, and staff initials to indicate the medications had been given. R4 R4's diagnoses included Alzheimer's disease and anxiety. R4's unsigned, service plan dated September 19, 2024, indicated R4 received services including medication management. R4's prescriber orders dated July 17, 2024, included one for depression and one for anxiety as needed. R4's MAR dated November 1, 2024, through November 18, 2024, included medications as prescribed, times to administer, and staff initials to indicate the mediations had been given. R1, R2, R3, and R4's record lacked a medication management plan to include: - procedures for staff notifying a registered nurse	01730		

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01730	Continued From page 36 or appropriate licensed health professional when a problem arises with medication management services. On November 20, 2024, at 2:30 p.m., CNS-B stated R1, R2, R3, and R4's records lacked a medication management plan to include the required content as noted above. CNS-B stated the licensee was working on building the requirement into their computerized software program. CNS-B further stated none of the licensee's current residents with medication management would have this requirement present in their record. The licensee's 7.03 Medication Management Individualized Plan policy dated August 1, 2021, noted the licensee would develop and maintain a current individualized medication management record for each resident that would contain procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date	01760		

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01760	Continued From page 37 and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of one unlicensed personnel (ULP-D) administered medications as prescribed. 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: R3's diagnoses included dementia and hypertension (high blood pressure). R3's unsigned, Service Plan dated November 9, 2024, indicated R3 received services including medication administration. R3's prescriber's orders dated September 18, 2024, included orders for: -diltiazem (for blood pressure) extended release (ER) 180 milligrams (mg) by mouth (PO) daily (QD). Hold if systolic (first/top number in a blood	01760		

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01760	Continued From page 38 pressure reading) blood pressure (SBP) < (less than) 100 or heart rate (HR) < 60. -metoprolol tartrate (for blood pressure) 25 mg PO twice daily (BID). Hold if SBP < or HR<60. R3's medication administration record (MAR) dated November 1, 2024, through November 18, 2024, included the same order for diltiazem ER 180 mg PO QD HOLD if SBP < 100 or HR < 60 and metoprolol tartrate 25 mg PO BID HOLD if SBP <100 or HR <60. On November 19, 2024, at 8:21 a.m., ULP-D was observed to check R3's blood pressure and pulse stating he had medications dependent on the results. ULP-D obtained a blood pressure reading of 118/63 and a pulse of 98 and then documented the results in R3's MAR. ULP-D stated she would have to hold R3's diltiazem ER and metoprolol tartrate as his SBP was greater than 100 and HR greater than 60. ULP-D then proceeded to prepare and administer the remaining scheduled medications to R3 in his room. Following R3's medication administration and documentation, the surveyor asked ULP-D what the symbol stood for in R3's diltiazem ER and metoprolol tartrate order. ULP-D stated the symbol meant greater than, not less than. On November 20, 2024, at 9:38 a.m., clinical nurse supervisor (CNS)-B stated ULP-D should have administered the medications as noted above and the MAR should have been worded more clearly (without symbols) to decrease confusion of the medication order. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		

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01940 SS=F	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 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 observation, interview, and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for three of	01940		

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01940	Continued From page 40 three residents (R1, R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on November 18, 2024, at 11:20 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided treatment management services to their residents. R1 R1's diagnoses included dementia. On November 19, 2024, at 11:51 a.m., the surveyor observed R1 wearing bilateral thrombo-embolic deterrent (TED) hose (compression socks used to increase circulation and reduce swelling in the legs) while seated in a wheelchair at the dining room table. R1's unsigned, service plan dated September 19, 2024, indicated R1 received assistance with TED hose. R1's prescriber orders dated January 25, 2024, included TED hose apply to bilateral lower extremities, on every morning and off at bedtime for circulation. R1's task completion record dated November 7, 2024, through November 19, 2024 included	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33524	A. BUILDING: _____ B. WING _____	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MOMENTS OF LAKEVILLE	16258 KENYON AVENUE LAKEVILLE, MN 55044

(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
01940	Continued From page 41 documentation R1 had TED hose on in the morning and off at bedtime. R1's treatment plan dated September 19, 2024, failed to include the following required content: - procedures for notifying a registered nurse when a problem arose with treatments or therapy services. R2 R2's diagnoses included congestive heart failure (when the heart can't pump blood well enough and blood and fluids collect in your lungs and legs over time), localized edema (swelling), and amnesia (loss of memory). On November 19, 2024, at 8:56 a.m., the surveyor observed R2 wearing bilateral TED hose while in his room. R2's unsigned, service plan dated September 26, 2024, indicated R2 received assistance with TED hose. R2's prescriber orders dated November 29, 2023, included TED hose on every morning and off at bedtime for bilateral lower extremity edema. R2's task completion record dated November 7, 2024, through November 19, 2024, included documentation R2 had TED hose on in the morning and off at bedtime. R2's treatment plan dated September 26, 2024, failed to include the following required content: - procedures for notifying a registered nurse when a problem arose with treatments or therapy services. R3	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33524	A. BUILDING: _____ B. WING _____	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MOMENTS OF LAKEVILLE	16258 KENYON AVENUE LAKEVILLE, MN 55044

(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
01940	Continued From page 42 R3's diagnoses included dementia and obstructive sleep apnea. On November 19, 2024, at 8:21 a.m., the surveyor observed R3 lying in bed with a continuous positive airway pressure (CPAP) (machine to keep your airways open while you sleep) on bedside table. Unlicensed personnel (ULP)-D stated R3 wore the CPAP at night when sleeping and the night staff remove and clean it every morning. R3's unsigned, service plan dated November 9, 2024, indicated R3 received services including bathing, dressing, hygiene/oral care, reminders for toileting, stand-by-assistance for transfers and ambulation, blood sugar management, and medication administration. The service plan failed to identify the treatment of CPAP assistance. R3's prescriber orders dated May 30, 2024, included to use CPAP at night. R3's task completion record dated November 7, 2024, through November 19, 2024, included documentation R3 had assistance with CPAP each night. R3's treatment plan dated September 26, 2024, failed to include the following required content: - procedures for notifying a registered nurse when a problem arose with treatments or therapy services. On November 20, 2024, at 2:30 p.m., CNS-B stated R1, R2, and R3's record lacked a treatment management plan to include all the required content as noted above. CNS-B stated the licensee was working on building the	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33524	A. BUILDING: _____ B. WING _____	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MOMENTS OF LAKEVILLE	16258 KENYON AVENUE LAKEVILLE, MN 55044

(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
01940	Continued From page 43 requirement into their computerized software program. CNS-B further stated none of the licensee's current residents with treatments would have this requirement present in their record. The licensee's 7.05 Treatment & Therapy Management Plan policy dated August 1, 2021, indicated the licensee would develop and maintain a current individualized treatment and therapy management record for each resident which would contain the following: - procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
02110 SS=C	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event	02110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33524	A. BUILDING: _____ B. WING _____	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MOMENTS OF LAKEVILLE	16258 KENYON AVENUE LAKEVILLE, MN 55044

(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
02110	Continued From page 44 a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in. This MN Requirement is not met as evidenced by: Based on interview and record review, licensee failed to ensure policies and procedures required in the licensing of assisted living facilities with dementia care were provided to each resident and/or the residents legal/designated representative at the time of move-in for four of four residents (R1, R2, R3, R4) who resided in an assisted living with dementia care facility. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents).	02110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33524	A. BUILDING: _____ B. WING _____	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MOMENTS OF LAKEVILLE	16258 KENYON AVENUE LAKEVILLE, MN 55044

(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
02110	Continued From page 45 The findings include: The licensee held an assisted living with dementia care license effective through November 30, 2024, and was licensed for a bed capacity of 101 residents. R1, R2, R3, and R4's records lacked documentation for receipt of the required Assisted Living with Dementia Care polices and procedures at the time of resident move-in, to include: - philosophy of how services were provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; - evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that were person-centered and evidence-informed; - wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; - medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; - staff training specific to dementia care; - description of life enrichment programs and how activities were implemented; - description of family support programs and efforts to keep the family engaged; - limited the use of public address and intercom systems for emergencies and evacuation drills only; - transportation coordination and assistance to and from outside medical appointments; and - safekeeping of resident's possessions.	02110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33524	A. BUILDING: _____ B. WING _____	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MOMENTS OF LAKEVILLE	16258 KENYON AVENUE LAKEVILLE, MN 55044

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02110	Continued From page 46 On November 20, 2024, at 2:36 p.m., business office manager (BOM)-C stated the dementia care policies had been developed, but not provided to the residents. BOM-C indicated this was a regulation she had been recently made aware of and had not implemented yet. The licensee's 3.00 Assisted Living with Dementia Care Additional Required Policies policy dated August 1, 2021, identified the required policies and procedures would be provided to residents and the residents' legal and designated representatives at the time of move-in. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02110		

Minnesota Department of Health
Environmental Health, FPLS
P.O Box 64975
Saint Paul
651-201-4500

Type: Full
Date: *11/19/24*
Time: 16:00:55
Report: 1018241203

Food and Beverage Establishment Inspection Report

Location:
The Moments Of Lakeville
16258 Kenyon Avenue
Lakeville, MN55044
Dakota County, 19

Establishment Info:
ID #: 0039397
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 9528731700
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.

3-300B Protection from Contamination: cross-contamination, eggs

3-302.11A(1) ***** Priority 1 *****

MN Rule 4626.0235A(1) Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.

RAW EGGS WERE OBSERVED TO BE STORED OVER RAW BEEF IN THE MAIN KITCHEN WALK IN COOLER. DISCUSSED WITH KITCHEN MANAGER THAN EGGS ARE A HIGHER COOK TEMP THAN BEEF, AND SHOULD BE STORED UNDERNEATH. COMPLY WITH RULE.

Comply By: 11/19/24

Surface and Equipment Sanitizers

Quaternary Ammonia: = 200PPM at Degrees Fahrenheit
Location: MAIN 3 COMP
Violation Issued: No

Quaternary Ammonia: = 400PPM at Degrees Fahrenheit
Location: UPSTAIRS 3 COMP
Violation Issued: No

Quaternary Ammonia: = 200PPM at Degrees Fahrenheit
Location: COTTAGE 3 COMP
Violation Issued: No

Hot Water: = at 170 Degrees Fahrenheit
Location: MAIN DISHWASHER
Violation Issued: No

Hot Water: = at 173 Degrees Fahrenheit
Location: UPSTAIRS DISHWASHER
Violation Issued: No

Hot Water: = at 166 Degrees Fahrenheit
Location: COTTAGE DISHWASHER
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding/ BEEF
Temperature: 40 Degrees Fahrenheit - Location: MAIN WALK IN
Violation Issued: No

Process/Item: Cold Holding/ CHEESE
Temperature: 40 Degrees Fahrenheit - Location: MAIN WALK IN
Violation Issued: No

Process/Item: Cold Holding/ MELON
Temperature: 37 Degrees Fahrenheit - Location: MAIN COOLER
Violation Issued: No

Process/Item: Cold Holding/ CHICKEN
Temperature: 38 Degrees Fahrenheit - Location: MAIN COOLER
Violation Issued: No

Process/Item: Cold Holding/ BEEF
Temperature: 39 Degrees Fahrenheit - Location: UPSTAIRS WALK IN
Violation Issued: No

Process/Item: Cold Holding/ CHEESE
Temperature: 39 Degrees Fahrenheit - Location: UPSTAIRS WALK IN
Violation Issued: No

Process/Item: Cold Holding/ BUTTER
Temperature: 40 Degrees Fahrenheit - Location: UPSTAIRS COOLER
Violation Issued: No

Process/Item: Cold Holding/ MELON
Temperature: 37 Degrees Fahrenheit - Location: THE COTTAGE COOLER
Violation Issued: No

Process/Item: Cold Holding/ SANDWICH
Temperature: 40 Degrees Fahrenheit - Location: THERAPY KITCHEN
Violation Issued: No

Process/Item: Cold Holding/ SANDWICH
Temperature: 40 Degrees Fahrenheit - Location: THERAPY KITCHEN
Violation Issued: No

Process/Item: Cold Holding/ SANDWICH
Temperature: 39 Degrees Fahrenheit - Location: THERAPY KICTHEN
Violation Issued: No

Process/Item: Cold Holding/SANDWICH
Temperature: 38 Degrees Fahrenheit - Location: THERAPY KITCHEN
Violation Issued: No

Type: Full
Date: *11/19/24*
Time: 16:00:55
Report: 1018241203
The Moments Of Lakeville

Food and Beverage Establishment Inspection Report

Process/Item: Cold Holding/ SANDWICH
Temperature: 40 Degrees Fahrenheit - Location: THERAPY KITCHEN
Violation Issued: No

Process/Item: Hot Holding/ SAUSAGE
Temperature: 151 Degrees Fahrenheit - Location: MAIN KITCHEN STEAM TABLE
Violation Issued: No

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

ESTABLISHMENT IS AN ASSISTED LIVING FACILITY WITH 3 MAIN KITCHENS. THERE ARE ALSO SEVERAL KITCHENETTES THROUGHOUT THE FACILITY THAT STORE SNACKS FOR THE RESIDENTS. THESE ARE LABELED AS THERAPY KITCHENS.

NO LARGE SCALE COOLING OR RE-HEATING IS DONE IN THE FACILITY.

NO FOOD ITEMS ARE KEPT LONGER THAN 4-5 DAYS.

VIEWED EMPLOYEE ILLNESS LOG.

DISCUSSED PEST CONTROL.

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 1018241203 of 11/19/24.

Certified Food Protection Manager: BEAU C LARSON

Certification Number: FM81025 Expires: 02/05/26

Inspection report reviewed with person in charge and emailed.

Signed: _____
BEAU LARSON
KITCHEN MANAGER

Signed: _____
Rebecca Prestwood
Sanitarian 3
6512013777
rebecca.prestwood@state.mn.us