Electronically Delivered

January 4, 2023

Licensee
Silvercrest Properties LLC
3633 Park Center Boulevard
Saint Louis Park, MN 55416

RE: Project Number(s) SL20427015

Dear Licensee:

The Minnesota Department of Health completed an evaluation on December 7, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's

resident(s)/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

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

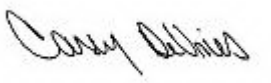
A state licensing order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.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

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

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

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

Sincerely,



Casey DeVries, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: casey.devries@state.mn.us
Phone: 651-201-5917 Fax: 651-215-6894

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20427	A. BUILDING: _____ B. WING _____	12/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVERCREST PROPERTIES LLC	3633 PARK CENTER BOULEVARD SAINT LOUIS PARK, MN 55416

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL20427015-0 On December 5, 2022, through December 7, 2022, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 75 residents, all of whom received services under the provider's Assisted Living with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living with Dementia Care licensed providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (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 according to the Minnesota Food Code. This had the potential to affect 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, 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: Please refer to the additional documentation included in the Food and Beverage Establishment	0 480		

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0 480	Continued From page 2 Inspection Reports, dated December 5, 2022. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 510 SS=E	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observations, interview, and record review, the facility failed to establish and maintain an effective infection control program that complied with accepted health care, medical and nursing standards for infection control related to gloving and hand hygiene, for three of nine residents (R2, R10, R11). 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 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	0 510		

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0 510	Continued From page 3 pervasive). The findings include: On December 6, 2022, at 7:10 a.m., unlicensed personnel (ULP)-K was observed in R2's apartment to don clean gloves without hand hygiene and assist R2 from the bed to the toilet. ULP-K assisted with the toilet, including removing the incontinence brief. The brief was observed to be soiled with urine and was placed into the bathroom trash receptacle. - Without removing the soiled gloves and hand hygiene, ULP-K was observed to wash R2's body, apply lotion, and provide perneal care. - Without removing the soiled gloves and hand hygiene, ULP-K handled and applied three, previously retrieved, medicated patches, and assisted R2 with dressing. In addition, hand hygiene was not offered to R2 after toileted. - Without removing the soiled gloves and performing hand hygiene, ULP-K was observed to don a pair of clean gloves. ULP-K then assisted R2 with oral cares. - Without changing the soiled gloves and without hand hygiene, ULP-K made the bed, picked-up the garbage and soiled linens from the bathroom. - Without changing the soiled gloves and hand hygiene, ULP-K filled a glass of water, washed R2's face, brushed hair and attached foot pedals to the wheelchair. ULP-K then removed the soiled gloves and without hand hygiene, pushed R2 to the community dining room. ULP-K then went back to R2's room and removed the trash from the bathroom, discarding it in the community trash room. ULP-K did not complete hand hygiene after discarding the trash. On December 6, 2022, at 7:45 a.m., ULP-K was observed to enter R11 and R10's apartment and	0 510		

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0 510	Continued From page 4	0 510		

without hand hygiene, don clean gloves, and assist R11 with dressing; R10 was observed dressed in a robe and appeared freshly showered. After assisting R11 with dressing, ULP-K washed the toilet seat off.
- Without removing soiled gloves and hand hygiene, ULP-K assisted R10 to the toilet.
- ULP-K removed the soiled gloves and without hand hygiene, was observed to leave the apartment, go to the common dining room, and obtain more gloves. ULP-K returned to the residents' apartment and without hand hygiene, donned clean gloves. ULP-K applied a clean incontinent brief, applied lotion, assisted with dressing and combed R10's hair. ULP-K then removed gloves and without hand hygiene, assisted with oral care and washed R10's face.
- Without hand hygiene, ULP-K handed R11 a hairbrush, retrieved a clean glass from kitchen cupboard, filled it with water for R10.

On December 6, 2022, at 8:17 a.m., ULP-K stated staff were to perform hand hygiene before working with food, upon entering or exiting a resident's room, before eating, after toilet, and anytime their hands were visibly soiled. In addition, ULP-K stated staff were to ask residents if they wanted to wash their hands after toilet, before eating, and if hands were visibly soiled.

On December 7, 2022, at 11:20 a.m., registered nurse-clinical director (RNDC)-C stated the staff were to perform hand hygiene before resident cares, before going into resident rooms, before passing medication, after removing gloves, "after doing anything dirty", and after cares. Staff were to change gloves after they "do the dirty [task]," then perform hand hygiene. Staff were to "never go glove-to-glove between patients [residents], or in the hallway [without hand hygiene]."

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0 510	Continued From page 5 The Centers for Disease Control (CDC) Hand Hygiene in Health Care Settings Healthcare Providers dated January 8, 2021, directed health care workers to wash their hands immediately before touching a patient [resident], after touching a patient or patient's immediate environment, after glove removal, and when hands were visibly soiled. The licensee's Hand washing policy dated August 1, 2021, directed hand washing (hand hygiene) should be completed: - Before, during, and after preparing food; - Before eating; - Before and after caring for someone who is sick; - Before and after treating a cut or wound; - After using the toilet; - After changing incontinent products or cleaning up after someone who has used the toilet; - After blowing nose, coughing, or sneezing; - After touching an animal or animal waste; - After handling pet food or pet treats; and - After touching garbage. In addition, when conducting a procedure requiring the use of gloves, proper hand hygiene should be completed before applying and after removing gloves. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control	0 660		

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0 660	Continued From page 6 program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), which included a completion of a two-step tuberculin skin test (TST) or other evidence of TB screening such as a blood test and a health history and symptom screening three of four employees (unlicensed personnel (ULP)-E, ULP- F, ULP-G). 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:	0 660		

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0 660	Continued From page 7 ULP-E ULP-E had a hire date of July 12, 2021. ULP-E's employee record lacked baseline screening of a two-step TST or other evidence of TB screening such as a blood test and lacked a health history and symptom screening. ULP-F ULP-F had a hire date of January 25, 2022. ULP-F's employee record lacked baseline screening of a two-step TST or other evidence of TB screening such as a blood test and lacked a health history and symptom screening. ULP-G ULP-G had a hire date of August 3, 2021. ULP-F's employee record lacked baseline screening of a two-step TST or other evidence of TB screening such as a blood test and lacked a health history and symptom screening. On December 6, 2022, at 9:15 a.m., regional human resources (RHR)-J stated, "There was confusion over licensure requirements" related to TB for a period of time. In addition, RHR-J stated the licensee was aware multiple employee records lacked TB screenings and health history and symptom screening and the licensee started to conduct audits on all employee records. On December 7, 2022, at 10:25 a.m., registered nurse-clinical director (RNCD)-C stated all new hires should be screened for TB upon hire. The licensee's Tuberculosis Screening policy dated August 1, 2021, indicated the licensee would establish and maintain a comprehensive	0 660		

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0 660	Continued From page 8 TB infection control program according to the most current TB infection control guidelines issued by the CDC, Division of Tuberculosis Elimination, as published int eh CDC's Morbidity and Mortality Weekly Report (MMWR). The CDC's MMWR dated May 16, 2019, indicated all health care personnel should have a baseline TB screening including an individual risk assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
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 tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually	0 680		

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0 680	Continued From page 9 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 interview and record review, the licensee failed to have a written emergency disaster plan with all required content. This had the potential to affect all seventy-five (75) residents receiving assisted living services, 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 the potential to affect a large portion or all of the residents). The findings include: On December 5, 2022, licensee's emergency preparedness plan lacked the following required content: - must establish/maintain a comprehensive emergency preparedness plan which describes described the facility's approach to meeting health/safety/security needs of staff/residents that would be reviewed/updated annually. -process for emergency preparedness cooperation with state and local emergency preparedness officials/organizations. -emergency preparedness training program for staff (including documentation of training provided).	0 680		

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0 680	Continued From page 10 -annual emergency preparedness testing requirements. On December 5, 2022, at 2:18 p.m., licensed assisted living director (LALD)-A confirmed licensee's emergency preparedness plan lacked the required content above. LALD-A stated licensee completed a community-based exercise but was unable to provide formal documentation of such exercise to surveyor. The licensee's Disaster Planning and Emergency Preparedness policy, dated August 1, 2021, indicated the licensee's intent would be to have in place an effective and compliant Emergency Preparedness Plan that would be in alignment with the Centers for Medicare and Medicaid Services State Operation Manual Appendix Z. Furthermore, the licensee's emergency preparedness plan would include all the required elements of appendix Z, be in writing, and reviewed annually. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of 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.	0 800		

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0 800	Continued From page 11 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect all residents and staff. 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 December 06, 2022, between 9:00 a.m. and 1:00 p.m., survey staff toured the facility with the director of environmental (DOE)-H and the Licensed Assisted Living Director (LALD)-A. During the facility tour, survey staff observed the following: 1. There was water damage to a large number of ceiling tiles in the corridor and lobby. During the interview, DOE-H stated that there were issues with the condensation pan drains for the air handling units above the ceiling had been plugged and were backed up causing water to drip onto the ceiling tiles and stain them. The issue had been addressed, but the tiles had not been replaced by the time of the survey. 2. While reviewing the annual maintenance inspection tags for the fire sprinkler riser, it was observed that the note on the inspection tag	0 800		

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SILVERCREST PROPERTIES LLC	3633 PARK CENTER BOULEVARD SAINT LOUIS PARK, MN 55416

(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
0 800	Continued From page 12 indicated the main drain leaked at the wall. During the interview, DOE-H stated that he was not aware of the finding. 3. The trash chute door on the fourth floor did not latch. The trash chute door should close and latch completely to maintain the fire resistance integrity of the trash chute system. 4. The cross-corridor fire-rated doors on the garden level that separated the independent living building from the assisted living building were propped open with a door wedge. The rubber wedge would prevent the doors from closing properly in the event of a fire. 5. The trash chute door on the fourth floor did not latch. The trash chute door should close and latch completely to maintain the fire resistance integrity of the trash chute system. There was a large hole cut in the fire-rated wall assembly above the trash chute which compromised the fire resistance integrity of the wall. 6. In most of the laundry rooms, it was observed that built-up lint was on the sprinkler heads and had accumulated dust behind the laundry equipment. 7. In the electrical room, the facility did not maintain the required clear floor space in front of the electrical panels. 8. The corridor by the Mechanical Room on the garden level was obstructed by furniture and chairs and compromised exiting due to not maintaining the path of egress. 9. At the exit door by the Mechanical room corridor on the garden level, outside snow and	0 800		

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0 800	Continued From page 13 debris made it difficult for the door to open completely. During the facility tour interview, LALD-A and DOE-H visually verified these deficient findings at the time of discovery. TIME PERIOD FOR CORRECTION: Twenty-one (21) 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 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.	0 810		

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0 810	Continued From page 14 (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 interview and record review, the licensee failed to develop and maintain fire safety and evacuation plans, failed to provide required training to residents and employees for fire safety and evacuation, and failed to conduct required employee evacuation drills. This had the potential to affect all current residents, staff, and visitors to 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, 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 residents). The findings include: During interview on December 06, 2022, at 12:00 p.m., the licensed assisted living director (LALD)-A stated they had not done any evacuation drills before September 2022, and they had not done any staff or resident training on the fire safety and evacuation plans. Review of the fire safety plan showed the following:	0 810		

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0 810	Continued From page 15 1. No evacuation plan or documentation on specific procedures for the residents including procedures for their movements, and relocation during a fire or similar emergency. No written instructions for addressing any unique situation during an evacuation, especially for residents who need assistance during an evacuation. 2. No record of required employee evacuation drills. 3. No schedule or records on the training of employees on fire safety and evacuation; on proper actions to take in the event of a fire or emergency for the safety of residents including movement, evacuation, or relocation. 4. No schedule or records on the training of residents who are capable of assisting in their evacuation; on proper actions to take in the event of a fire or emergency for their safety including movement, evacuation, or relocation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 970 SS=C	144.50 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.	0 970		

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0 970	Continued From page 16 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the facility'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 of the residents). The findings include: On December 5, 2022, at approximately 12:00 p.m., licensed assisted living director (LALD)-A provided the surveyor with a blank Assisted Living Contract : Terms & Conditions and indicated the contract was used by licensee for all residents who received services. The contract included the following three sections: - Liability which read, "Provider is not liable to Resident or Resident's guests for any injury, death or property damage occurring in the Apartment or on Provider's premises unless such injury, death or property damage occurs as the result of Provider's own negligent acts or omissions, or those of its employees, officers, managers, owners or agents. Provider is also not liable for any injury death or damage occurring as the result of Resident's receipt of health-related, supportive or other services from third party providers. Unless caused by one of the	0 970		

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0 970	Continued From page 17 aforementioned excepted reasons, Resident agrees to hold Provider harmless form any and all claims for injuries, property damage or any other loss resulting from and accident or other occurrence in the Apartment or on the Provider's premises."; - Personal Property which read, "Resident agrees that Provider is not responsible for any loss or damage to Resident's personal property due to any reason or cause, including theft, other than Provider's own negligence."; and -Indemnification which read, "Resident assumes the risk for Resident's own safety and for the safety of Resident's guests and agents. Resident will indemnify and hold harmless Provider, its employees, officers, managers, owners and agents from and against any and all claims, actions, damages, and liability and expense in connection with loss of life, personal injury or damage to property, arising from or out of , or caused wholly or in part by, an act or omission of Resident or Resident's guests or agents." On December 7, 2022, at 10:51 a.m., regional director of operations (RDO)-L stated the licensee became aware of the requirement listed above on a Care Provider call and stated the contract would need to be revised. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 970		
01370 SS=D	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all	01370		

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01370	Continued From page 18 unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by:	01370		

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01370	Continued From page 19 Based on interview and record review, the licensee failed to ensure a registered nurse (RN) trained and competency evaluated staff in all required topics for one of two employees (unlicensed personnel (ULP)-E. 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: ULP-E was hired on July 21, 2021, under the comprehensive home care license. ULP-E began providing assisted living services after August 1, 2021. ULP-E's employee training records lacked evidence successful completion of practical skills evaluations as required for training in accordance with assisted living 144G statutes in the following areas: -documentation requirements for all services provided; -reports of changes in the resident's condition to the supervisor designated by the facility; -maintenance of a clean and safe environment; -basic nutrition, meal preparation, food safety, and assistance with eating; -awareness of commonly used health technology equipment and assistive devices. On December 6, 2022, at 10:02, regional human resources (RHR)-J confirmed the licensee failed to ensure the RN had trained and competency	01370		

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01370	Continued From page 20 tested the ULP"s prior to delegating tasks. The licensee's Competency Training Evaluations policy dated August 1, 2021, indicated the above content would be included in the training and competency evaluations for all ULP's, and a copy of all education, training and competency testing would be kept in each employee's personnel file. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	01370		
01440 SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not	01440		

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01440	Continued From page 21 performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) completed supervision of a ULP within 30 calendar days of beginning to provide delegated tasks for three of three employees (unlicensed personnel (ULP)-E, ULP-F, ULP-G). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-E had a hire date of July 12, 2021, and began to provide Assisted living services August 1, 2021. On December 6, 2022, at 11 a.m., ULP-E was observed to perform a blood glucose test on R4. ULP-E record lacked evidence a RN conducted direct supervision of ULP-D within 30 days of performing delegated tasks. ULP-F ULP-F had a hire date of January 25, 2022. ULP-F's record contained a document titled New Hire Orientation - CNA (certified nursing assistant) signed January 25, 2022, included	01440		

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01440	Continued From page 22 medication administration training. ULP-F's record lacked evidence a RN conducted direct supervision of ULP-D within 30-days of hire. ULP-G ULP-G had a hire date of August 3, 2021. On December 6, 2022, between 7:12 a.m. and 7:55 a.m., ULP-G was observed to administer oral medications to five residents. ULP-G record lacked evidence a RN conducted direct supervision of ULP-D within 30-days of performing a delegated task. On December 7, 2022, at 10:41 a.m., registered nurse-clinical director (RNCD)-C stated they had conducted 30-day supervisions on ULP's hired after spring 2022 and lacked documentation of 30-day supervisions on employees hired prior to spring 2022. In addition, RNCD-C stated they were unaware of why records of employees hired prior to spring of 2022 lacked 30-day supervisions because they were not employed by the licensee. The licensee's Supervision of Staff - Delegated Services policy dated August 1, 2021, indicated direct supervision of a staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the licensee, when a staff first performs the delegated tasks for residents, and thereafter as needed on performance. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440		

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01460 SS=D	144G.63 Subdivision 1 Orientation of staff and supervisors All staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. The orientation may be incorporated into the training required under subdivision 5. The orientation need only be completed once for each staff person and is not transferable to another facility. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, licensee failed to ensure employees received orientation to the assisted living licensing requirements and regulations before providing direct care services for two of four employees (registered nurse (RN)-D, unlicensed personnel (ULP)-G). 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: RN-D RN-D had a hire date of August 22, 2022. RN-D employee record lacked orientation to the assisted living licensing requirements and	01460		

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01460	Continued From page 24 regulations. ULP-G ULP-G had a hire date of August 3, 2021. On December 6, 2022, between 7:12 a.m. and 7:55 a.m., ULP-G was observed to administer oral medications to five residents. ULP-G employee record included orientation to the assisted living licensing requirements and regulations on January 19, 2022, 169 days after employment start date. ULP-G employee record lacked documentation of orientation prior to providing direct care services to residents. On December 6, 2022, at 9:10 a.m., regional human resources (RHR)-J stated staff were supposed to turn in an orientation checklist to cooperate once completed. In addition, RHR-J stated the licensee had no record of RN-D orientation. On December 7, 2022, at 10:07 a.m., registered nurse-clinical director (RNCD)-C verified RN-D and ULP-G's employee records lacked the content above and stated human resources is responsible for employee record information. RNCD-C stated all staff attended a cooperate orientation that included orientation training to the assisted living licensing requirements and regulations. The licensee's Orientation of Staff and Supervisors & Content policy dated August 1, 2021, indicated all staff providing and supervising direct services must complete an orientation to Assisted Living facility licensing requirements and regulation before providing assisted living services to residents.	01460		

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01460	Continued From page 25 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01460		
01540 SS=E	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED (3) for assisted living facilities with dementia care, direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 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; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure all staff received eight hours of initial dementia care training within the first 80 working hours of employment for direct care employees as required for three of four employees (unlicensed personnel (ULP)-E, ULP-F, ULP-G). This practice resulted in a level two violation (a	01540		

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01540	Continued From page 26	01540		

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:

ULP-E
ULP-E had a hire date of July 12, 2021.

ULP-E employee record included 5.75 hours of dementia care training completed between March 4, 2022, and March 28, 2022. ULP-F's record lacked eight hours of initial dementia care training withing the first 80 hours of employment.

ULP-F
ULP-F had a hire date of January 25, 2022.

ULP-F employee record included 7.75 hours of dementia care training completed between January 27, 2022, and March 30, 2022. ULP-F's record lacked eight hours of initial dementia care training withing the first 80 hours of employment.

ULP-G
ULP-G had a hire date of August 3, 2021.

ULP-G employee record included 5.75 hours of dementia care training completed between March 4, 2022, and March 20, 2022. ULP-G's record lacked eight hours of initial dementia care training withing the first 80 hours of employment.

On December 6, 2022, at 10:02, regional human

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01540	Continued From page 27 resources (RHR)-J stated the licensee had a change of ownership August 1, 2021, and ULP-G training may have been missed due to the changeover of companies. On December 7, 2022, at 10:23 a.m., registered nurse-clinical director (RNCD)-C stated employees received the 5 required modules of dementia care training on EduCare (a software training system). RN-A stated they were unaware the 5 modules contained 5.75 hours of dementia training not the required 8 hours. The licensee's Dementia Training policy dated August 1, 2021, indicated direct care employees would complete eight hours of initial dementia care training within 80 hours of the employment start date. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01540		
01650 SS=D	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes:	01650		

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01650	Continued From page 28 (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 the service plan included the required content for two of five residents (R2, R6). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 R2 admitted for services on August 18, 2020. R2 diagnoses included hypertension, dementia without behavioral disturbances, altered mental	01650		

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01650	Continued From page 29 status, and delusional disorders. R2's signed service plan dated November 21, 2022, lacked identification of circumstances in which emergency medical services are not to be summoned. R6 R6 admitted to the licensee for services on July 26, 2021, under the comprehensive license, and on August 1, 2021, under the assisted living license. R6's diagnoses included Alzheimer's disease, hypertension, obstructive sleep apnea, osteoporosis, squamous cell carcinoma (cancer) of the skin. R6's Assisted Living Service Addendum signed January 28, 2022, indicated R6 received assistance with medication management, INR management, bathing assistance, grooming, dressing, toileting, laundry, housekeeping, transfers, end of life package, and mobility. R6's service plan lacked the following required content: - a description of the frequency of each service, according to the resident's current assessment and resident preferences; - the methods of monitoring assessments of the resident; - the schedule and methods of monitoring staff providing services; - a contingency plan that includes the action to be taken if the scheduled service cannot be provided; 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.	01650		

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01650	Continued From page 30 On December 7, 2022, at 10:38 a.m., registered nurse-clinical director (RNCD)-C stated in spring 2022 the licensee switched service plan templates to include all required content per Assisted Living statutes. In addition, RNCD-C stated approximately 50 percent of the residents service plans were updated with the new service plan template. The licensee's Service Plans policy dated August 1, 2022, indicated all required content would be included in the service plan per 144G.70 subd. 4. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	01650		
01730 SS=D	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	01730		

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01730	Continued From page 31 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 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 ensure the individualized medication management plan included all required content for one of seven residents (R5). This had the potential to affect all 75 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 an isolated scope (when one or a limited number of residents are affected or one or a limited number	01730		

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01730	Continued From page 32 of staff are involved, or the situation has occurred only occasionally. The findings include: R5's diagnoses included, but were not limited to, history of pulmonary embolism, systolic congestive heart failure, anemia, hypertension, and chronic kidney disease. R5's medication management plan was dated November 18, 2022. The medication management plan did not include documentation of specific resident instructions relating to complex medication regimen (i.e., cut or crush tablets). On December 6, 2022, at 7:05 a.m., the surveyor observed unlicensed personnel (ULP)-E crush aspirin EC 81mg tablet in applesauce and administer the medication to R5. On December 6, 2022, at 7:10 a.m., the surveyor observed ULP-E document medication administration on the EMAR for R5's administration of Aspirin EC 81mg tablet and proceed to prepare medication administration for another resident. On December 6, 2022, at 10:07 a.m., registered nurse clinical director (RNCD)-C verified R5's medication management plan dated November 18, 2022, and R5's physician's order dated November 11, 2022, lacked directions for R5's Aspirin EC 81mg tablet to be crushed prior to administration. RNCD-C stated that she was unaware that ULP-E was crushing R5's medication and stated that she was going to obtain an MD order to have R5's Aspirin EC 81mg switched to a chewable form.	01730		

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01730	Continued From page 33 The licensee's Medication and Treatment-Administration and Delegation policy dated August 1, 2021, indicated an RN would instruct the ULP on the following medication administration tasks before delegating the task to them: The preparation of medication for administration. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01760 SS=E	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 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 medications were administered per providers orders for four of seven residents (R5, R6, R7, R8).	01760		

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01760	Continued From page 34 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: R5 R5's Assisted Living Service Addendum signed October 7, 2022, indicated R5 received assistance with medication management, bathing assistance, dressing, toileting, laundry, housekeeping, transfers, daily blood pressure, daily pulse, monthly weight, respirations, oxygen saturation, and hearing aid assistance. R5's Med Admin Summary dated December 1, 2022, through December 31, 2022, included one tablet of Carvedilol 3.125mg twice daily with a meal (hold for pulse <50 or systolic blood pressure <100). On December 6, 2022, at 7:05 a.m., the surveyor observed unlicensed personnel (ULP)-E fail to check R5's pulse or blood pressure prior to the administration of Carvedilol 3.125mg. On December 6, 2022, at 7:10 a.m., the surveyor observed ULP-E document medication administration on the EMAR for R5's administration of Carvedilol 3.125mg and proceed to prepare medication administration for another resident.	01760		

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01760	Continued From page 35 On December 6, 2022, at 7:12 a.m., ULP-E stated the pulse oximeter was not always on the medication cart and sometimes R5 leaves the building before vital signs can be obtained. In addition, ULP-E stated, "I usually just let the nurse know if R5's pulse and blood pressure were not obtained prior to administration of Carvedilol." On December 6, 2022, at 10:07 a.m., registered nurse clinical director (RNCD)-C confirmed the directions for medication administration were place in RTask and were located on the medication administration record. RNCD-C stated that she did not know why ULP's were not obtaining vital signs prior to medication administration per MD orders. R6 R6's Assisted Living Service Addendum signed January 28, 2022, indicated R6 received assistance with medication management, INR management, bathing assistance, grooming, dressing, toileting, laundry, housekeeping, transfers, end of life package, and mobility. R6's Med Admin Summary dated December 1, 2022, through December 31, 2022, included one tablet of calcium 600 milligrams (mg) / vitamin D 400 units (U) daily, Lidocaine 4 percent (%) topical patch one patch cut in half, apply half patch to each knee at 8:00 a.m. and remove at 8:00 p.m., and Lidocaine 4% topical patch apply two patches to lower back at 8:00 a.m. and remove at 8:00 p.m. On December 6, 2022, at approximately 7:15 a.m., the surveyor observed unlicensed personnel (ULP)-K apply a whole Lidocaine 4% topical patch to each knee on R2. In addition, the	01760		

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01760	Continued From page 36 surveyor did not observe the use of the electronic medication administration record (EMAR) prior to the application of two Lidocaine 4% topical patches. On December 6, 2022, at approximately 7:23 a.m., the surveyor observed ULP-K apply one Lidocaine 4% topical patch to R2's back. In addition, the surveyor did not observe the use of the EMAR prior to the application of two Lidocaine 4% topical patches. On December 6, 2022, R6's Med Admin Summary dated December 1, 2022, through December 31, 2022, indicated ULP-G administered the three Lidocaine 4% topical patches. On December 6, 2022, at 7:41 a.m., the surveyor observed ULP-G document verified on the EMAR for calcium 600 mg / vitamin D 400 U daily and dispensed one tablet of calcium 600 mg / vitamin D 800 U R6. ULP-G locked medication cart and proceeded to walk to administer medication to R6. The surveyor intervened to stop medication administration of calcium 600 mg / vitamin D 800 U to R6. On December 6, 2022, at 7:44 a.m., ULP-G stated they believed the division sign between the two numbers indicated a half dose of the medication. R7 R7's Available Assisted Living Service Packages & Fees and Service Plan signed October 27, 2021, indicated R7 received assistance with personal cares, health checks, medication administration, mobility, socialization, homemaking, and laundry.	01760		

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01760	Continued From page 37 R7's provider orders dated October 11, 2021, included cholecalciferol 2,000 U daily. On December 6, 2022, at 7:26 a.m., the surveyor observed ULP-G document verified on the EMAR for cholecalciferol 2,000 U and dispensed one tablet cholecalciferol 5,000 U for R7. ULP-G locked medication cart and proceeded to walk to administer medication to R7. The surveyor intervened to stop medication administration of 5,000 U of cholecalciferol to R7. On December 6, 2022, at 7:30 a.m., ULP-G stated they were administering one tablet of Vitamin D as indicated on the EMAR. The surveyor inquired what would be done regarding the medication. ULP-G stated they would notify a nurse. On December 6, 2022, at 7:57 a.m., registered nurse (RN)-D stated R6 and R7 had a medication error on the medications listed above and they had contacted the provider. In addition, RN-A stated families may provide residents over the counter (OTC) medications and may have brought the medications in to the facility after hours where it was placed into the medication cart before being verified by the nurse to administer. R8 The licensee's Medication Observation Audit dated 2019, directed staff to match the medication label to the order on the EMAR. The licensee's New Hire Orientation -CNA dated November 11, 2021, indicated ULP's received medication administration training through	01760		

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01760	Continued From page 38 EduCare (a training software) on the six rights of medication administration which included the right dose. No further information provided TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01830 SS=F	144G.71 Subd. 14 Renewal of prescriptions Prescriptions must be renewed at least every 12 months or more frequently as indicated by the assessment in subdivision 2. Prescriptions for controlled substances must comply with chapter 152. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure prescriptions were renewed at least every 12 months for one of five residents (R7). 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: R7 admitted to the licensee for services on November 16, 2021.	01830		

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01830	Continued From page 39 R7's diagnoses included Alzheimer's disease and HTN. R7's Available Assisted Living Service Packages & Fees and Service Plan signed October 27, 2021, indicated R7 received assistance with personal cares, health checks, medication administration, mobility, socialization, homemaking and laundry. R7's most recent provider orders for 6 medications were signed on October 11, 2021. On December 7, 2022, at 10:49 a.m., registered nurse-clinical director (RNCD)-C stated prescriptions should be renewed every 12 months. In addition, RNCD-C stated there were multiple residents without orders renewed every 12 months however, they had recognized there was an issue with prescription renewal and started to send medication and treatment orders to the providers to sign. The licensee's Medication & Treatment Orders - Renewal policy dated August 1, 2021, indicated medication and treatment orders must be renewed every 12 months or more frequently as required. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01830		
01880 SS=D	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20427	A. BUILDING: _____ B. WING _____	12/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVERCREST PROPERTIES LLC	3633 PARK CENTER BOULEVARD SAINT LOUIS PARK, MN 55416

(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
01880	Continued From page 40 according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observations, interview and record review, the licensee failed to store prescription medication securely and permit only authorized personnel to have access for one of three medication carts. 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 December 6, 2022, at 8:28 a.m., the surveyor exited the elevator with registered nurse (RN)-D. RN-D than entered the nurses office, passing the first-floor assisted living medication cart located outside the nursing station and in close proximity to the front entrance. The surveyor observed the first-floor assisted living medication cart which contained ten resident's medications including one narcotic, unlocked and unattended for approximately three minutes. RN-D exited the nursing office and witnessed the surveyor opening drawers. The surveyor informed RN-D the cart was left unlocked and unattended and needed to be locked. RN-D than locked the first-floor assisted living medication cart. On December 7, 2022, at approximately 11:20	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20427	A. BUILDING: _____ B. WING _____	12/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVERCREST PROPERTIES LLC	3633 PARK CENTER BOULEVARD SAINT LOUIS PARK, MN 55416

(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
01880	Continued From page 41 a.m., registered nurse-clinical director (RNDC)-C stated the staff were to keep the medication carts locked at all times when not in use and all narcotics should be kept under a double lock. The licensee's Medication Storage policy dated August 1, 2021, indicated medications managed outside of a resident's private "living space" must be securely locked and in substantially constructed compartments and permit only authorized personnel to have access. In addition, scheduled II drugs would be stored under a double lock system and stored separately from other medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on [observation] interview and record	02040		

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	20427	A. BUILDING: _____ B. WING _____	12/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVERCREST PROPERTIES LLC	3633 PARK CENTER BOULEVARD SAINT LOUIS PARK, MN 55416

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02040	Continued From page 42 review, the licensee failed to conduct a hazard vulnerability or safety risk assessment on or around the facility property. 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 the potential to affect a large portion or all residents). The findings include: Survey staff requested a facility hazard vulnerability or safety risk assessment documentation, but the licensee did not provide the requested documentation. No hazard vulnerability assessment had been completed on and around the property at the time of the survey. During interview on December 06, 2022, at 12:30 p.m., the director of environmental (DOE)-H stated he had started in the position in September 2022 and had not completed the assessment yet. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		
02110 SS=D	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	02110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20427	A. BUILDING: _____ B. WING _____	12/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVERCREST PROPERTIES LLC	3633 PARK CENTER BOULEVARD SAINT LOUIS PARK, MN 55416

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02110	Continued From page 43 procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure policies and procedures for assisted living with dementia care were provided to residents and the residents legal and designated representatives at the time of move-in	02110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20427	A. BUILDING: _____ B. WING _____	12/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVERCREST PROPERTIES LLC	3633 PARK CENTER BOULEVARD SAINT LOUIS PARK, MN 55416

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02110	Continued From page 44 for one of five residents (R6). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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: R6 admitted to the licensee for services on July 26, 2021, under the comprehensive license, and on August 1, 2021, under the assisted living license. R6's Assisted Living Service Addendum signed January 28, 2022, indicated R6 received assistance with medication management, INR management, bathing assistance, grooming, dressing, toileting, laundry, housekeeping, transfers, end of life package, and mobility. R6's record lacked evidence R6 and/or R6's legal and designated representative were provided the facility's policies and procedures related to assisted living with dementia care, as required. On December 7, 2022, at 9:57 a.m., licensed assisted living director (LALD)-D verified R6's medical record lacked evidence that R6 and/or R6's legal and designated representative were provided the licensee's policies and procedures related to dementia care. On December 7, 2022, at 10:29 a.m., at registered nurse-clinical director (RNCD)-C	02110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20427	A. BUILDING: _____ B. WING _____	12/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVERCREST PROPERTIES LLC	3633 PARK CENTER BOULEVARD SAINT LOUIS PARK, MN 55416

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02110	Continued From page 45 stated dementia policies were provided to residents or resident families upon admission to the licensee by marketing. The licensee's Assisted Living with Dementia Care Additional Required Policies dated December 6, 2021, and November 17, 2022, indicated the following policies and procedures must be provided to residents and the residents' legal and designated representative by the time of move-in: - 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; - evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are 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 are implemented; - description of family support programs and efforts to keep the family engaged; - limiting 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 residents' possessions. No further information was provided.	02110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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02110	Continued From page 46 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02110		

Minnesota Department of Health

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

Type: Full
Date: *12/05/22*
Time: 10:30:00
Report: 8087221277

Food and Beverage Establishment Inspection Report

Location:
Silvercrest Properties Llc
3633 Park Center Boulevard
St Louis Park, MN55416
Hennepin County, 27

Establishment Info:
ID #: 0039080
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 9528485803
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.

4-600 Cleaning Equipment and Utensils

4-602.11C ** Priority 1 **

MN Rule 4626.0845C Clean food-contact surfaces of equipment and utensils used for TCS foods, at least every 4 hour.

ICE SCOOPS ARE BEING STORED ON TOP OF ICE MACHINE. ICE SCOOPS WERE MOVED TO A CLEAN AREA BY MANAGEMENT. CORRECTED ON SITE.

Corrected on Site

4-200 Equipment Design and Construction

4-201.11FMN

MN Rule 4626.0506F Replace the equipment in a neighborhood kitchen with equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program so grease and moisture does not accumulate on adjacent surfaces.

HOOD BAFFLES ABOVE COOKING AREA ARE SOILED AND ACCUMULATING ON ADJACENT SURFACES. CLEAN AND MAINTAIN CLEAN THE HOOD BAFFLES ABOVE THE COOKING AREA TO COMPLY WITH THE RULE ABOVE.

Comply By: 12/09/22

Surface and Equipment Sanitizers

Quaternary Ammonia: = 200 PPM at -- Degrees Fahrenheit
Location: WIPING CLOTH BUCKET
Violation Issued: No

Chlorine: = 100 PPM at 126 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Quaternary Ammonia: = 400 PPM at -- Degrees Fahrenheit
Location: WALL DISPENSING UNIT
Violation Issued: No

Quaternary Ammonia: = 400 PPM at -- Degrees Fahrenheit
Location: WIPING CLOTH BUCKET
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Ambient Air
Temperature: -11 Degrees Fahrenheit - Location: WALK-IN FREEZER
Violation Issued: No

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

Process/Item: Cold Holding: GROUND BEEF
Temperature: 38 Degrees Fahrenheit - Location: STAND-UP COOLER - BIG
Violation Issued: No

Process/Item: Cold Holding: MILK
Temperature: 38 Degrees Fahrenheit - Location: STAND-UP COOLER - BIG
Violation Issued: No

Process/Item: Cold Holding: SOFT CHEESE
Temperature: 39 Degrees Fahrenheit - Location: STAND-UP COOLER - BIG
Violation Issued: No

Process/Item: Ambient Air
Temperature: 10 Degrees Fahrenheit - Location: STAND-UP FREEZER
Violation Issued: No

Process/Item: Ambient Air
Temperature: 38 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

Process/Item: Cold Holding: DELI MEAT
Temperature: 36 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

Process/Item: Cold Holding: YOGURT
Temperature: 36 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

Process/Item: Cold Holding: CHEESE
Temperature: 37 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

Process/Item: Cold Holding: PORK SAUSAGE
Temperature: 35 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

Food and Beverage Establishment Inspection Report

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

Process/Item: Cold Holding: MILK
Temperature: 38 Degrees Fahrenheit - Location: STAND-UP COOLER - SMALL
Violation Issued: No

Process/Item: Re-Heating: SOUP
Temperature: 166 Degrees Fahrenheit - Location: STOVE TOP
Violation Issued: No

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

THIS WAS AN UNANNOUNCED AND UNSCHEDULED FULL INSPECTION.

INSPECTION DONE WITH KITCHEN MANAGER JOHN A. CAZA.

TOPICS OF DISCUSSION WITH OPERATOR INCLUDED:

HAND WASHING
NOROVIRUS
BARE HAND CONTACT WITH READY TO EAT FOODS
EMPLOYEE ILLNESS
EMPLOYEE EXCLUSION
COOLING METHODS
REHEATING METHODS
SANITIZER CONCENTRATION
DATE MARKING
ALL ITEMS ON THIS REPORT
ALL ITEMS ON PREVIOUS REPORT

ALL FROZEN FOODS FOUND IN FROZEN CONDITION.

REPORT EMAILED TO RN AND STATE EVALUATOR RHONDA MAKELA..

Type: Full
Date: *12/05/22*
Time: 10:30:00
Report: 8087221277
Silvercrest Properties Llc

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 8087221277 of 12/05/22.

Certified Food Protection Manager: JOHN A. CAZA

Certification Number: FM51928 Expires: 02/12/25

Inspection report reviewed with person in charge and emailed.

Signed: _____

JOHN A. CAZA
KITCHEN MANAGER

Signed: _____

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