



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

March 18, 2024

Licensee
Midwest Residential, Inc.
421 Hemlock Drive
Burnsville, MN 55337

RE: Project Number(s) SL37548015

Dear Licensee:

On March 14, 2024, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on January 4, 2024. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the January 4, 2024 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on January 4, 2024, found not corrected at the time of the March 14, 2024, follow-up survey and/or subject to penalty assessment are as follows:

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

The details of the violations noted at the time of this follow-up survey completed on March 14, 2024 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

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

DOCUMENTATION OF ACTION TO COMPLY

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

IMPOSITION OF FINES:

Level 1: no fines or enforcement.

Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in §144G.20 for widespread violations;

Level 3: a fine of \$3,000 per violation per incident, in addition to any enforcement mechanism authorized in §144G.20.

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

CORRECTION ORDER RECONSIDERATION PROCESS

In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request

for reconsideration must be in writing and received by MDH within 15 calendar days of the correction order receipt date.

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

To submit a reconsideration request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

REQUESTING A HEARING

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

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

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

We urge you to review these orders carefully. If you have questions, please contact Jessie Chenze at 218-332-5175.

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

Sincerely,

A handwritten signature in black ink that reads "Jessie Chenze". The signature is written in a cursive, flowing style.

Jessie Chenze, Supervisor
State Evaluation Team
Email: jessie.chenze@state.mn.us
Telephone: 218-332-5175 Fax: 1-866-890-9290

PMB

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37548	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 03/14/2024
NAME OF PROVIDER OR SUPPLIER MIDWEST RESIDENTIAL INC		STREET ADDRESS, CITY, STATE, ZIP CODE 421 HEMLOCK DRIVE BURNSVILLE, MN 55337			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
{0 000}	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL37548015-1 On March 11, 2024, through March 14, 2024, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on January 4, 2024. At the time of the survey, there were six residents; all of whom were receiving services under the Assisted Living license. As a result of the revisit, the following orders were reissued.	{0 000}	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.		
{0 480} SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the	{0 480}			

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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{0 480}	Continued From page 1 following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: No further action required.	{0 480}			
{0 780} SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced	{0 780}			

Minnesota Department of Health

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{0 780}	Continued From page 2 by: Based on observation and interview, the licensee failed to provide smoke alarms that are interconnected so that actuation of one alarm causes all alarms in the dwelling unit to actuate and failed to provide working smoke alarm in the immediate vicinity of the sleeping #6. This affected all staff and 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: On March 14, 2024, at 12:00 p.m., survey staff toured the facility with license assisted living director (LALD)-E. It was observed a smoke alarm was not installed in immediately outside of sleeping room #6 on the lower level. It was also observed upon testing that the smoke alarm immediately outside of sleeping room #4 on the main level was not interconnected with the rest of the smoke alarms in the facility, so the actuation of one alarm would cause all alarms to operate. During the interview on March 14, 2024, at 12:30 p.m., LALD-E confirmed that the licensee failed to provide interconnected smoke alarms immediately outside sleeping room #4 on the main level and a smoke alarm outside the sleeping room #6.	{0 780}			

Minnesota Department of Health

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{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 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: No further action required.	{01760}			



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January 18, 2024

Licensee
Midwest Residential, Inc.
421 Hemlock Drive
Burnsville, MN 55337

RE: Project Number(s) SL37548015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on January 4, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

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

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5), the MDH may impose fine amounts of either \$1,000 or \$5,000 to licensees who are found to be responsible for maltreatment.

The MDH may impose a fine of \$1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The MDH

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

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

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

St - 0 - 0820 - 144g.45 Subd. 2 (g) - Fire Protection And Physical Environment = \$3,000.00

St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required = \$3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$6,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

REQUESTING A HEARING

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

Midwest Residential, Inc.

January 18, 2024

Page 3

correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. to submit a hearing request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

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

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,

A handwritten signature in black ink, appearing to read "Jodi Johnson", with a stylized flourish extending to the right.

Jodi Johnson, Supervisor

State Evaluation Team

Email: jodi.johnson@state.mn.us

Telephone: 507-344-2730 Fax: 1-866-890-9290

PMB

Minnesota Department of Health

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0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL37548015-0 On January 2, 2024, through January 4, 2024, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were five residents; five receiving services under the Assisted Living license. 0820: An immediate correction order was issued on January 4, 2024. The immediacy was not lifted at the time of survey exit. 1290: An immediate correction order was issued on January 3, 2024. The immediacy was removed on January 4, 2024; however, non-compliance remains at a level 3, widespread (I).	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.		
0 250 SS=F	144G.20 Subdivision 1 Conditions	0 250			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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0 250	Continued From page 1 (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4, or interferes with or impedes access by the Office of Ombudsman for Mental Health and Developmental Disabilities according to section 245.94, subdivision 1; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living	0 250			

Minnesota Department of Health

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0 250	Continued From page 2 facility's compliance with this chapter; (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to show they met the requirements of licensure, by attesting the managerial officials who oversaw the day-to-day operations understood applicable statutes and rules; nor developed and/or implemented current policies and procedures as required with records reviewed. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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:	0 250			

Minnesota Department of Health

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0 250	Continued From page 3 During the entrance conference on January 2, 2024, at 11:30 a.m., licensed assisted living director (LALD)-E and licensed practical nurse (LPN)-C stated the licensee's employees in charge of the facility were familiar with the assisted living regulations and the licensee provided medication and treatment management services. The licensee's Application for Assisted Living License, section titled Official Verification of Owner or Authorized Agent, (page five and six of the application), identified, I certify I have read and understand the following: [a check mark was placed before each of the following]: - I have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section] 144G.45, my building(s) must comply with subdivisions 1-3 of the section, as applicable section Laws 2020, 7th Spec. [special] Sess [session]., chpt. [chapter] 1. art. [article] 6, sect. 17. - I have read and fully understand Minn. Stat. sect. 144G.80, 144G.81. and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22, my building(s) must comply with these sections if applicable. - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G. - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659. - Reporting of Maltreatment of Vulnerable Adults. - Electronic Monitoring in Certain Facilities.	0 250			

Minnesota Department of Health

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0 250	Continued From page 4 - I understand pursuant to Minn. Stat. sect. 13.04 Rights of Subjects of Data, the Commissioner will use information provided in this application, which may include an in-person or telephone conference, to determine if the applicant meets requirements for assisted living licensing. I understand I am not legally required to supply the requested information; however, failure to provide information or the submission of false or misleading information may delay the processing of my application or may be grounds for denying a license. I understand that information submitted to the commissioner in this application may, in some circumstances, be disclosed to the appropriate state, federal or local agency and law enforcement office to enhance investigative or enforcement efforts or further a public health protective process. Types of offices include Adult Protective Services, offices of the ombudsmen, health-licensing boards, Department of Human Services, county or city attorneys' offices, police, local or county public health offices. - I understand in accordance with Minn. Stat. sect. 144.051 Data Relating to Licensed and Registered Persons (opens in a new window), all data submitted on this application shall be classified as public information upon issuance of a provisional license or license. All data submitted are considered private until MDH issues a license. - I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659 governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or	0 250			

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER MIDWEST RESIDENTIAL INC		STREET ADDRESS, CITY, STATE, ZIP CODE 421 HEMLOCK DRIVE BURNSVILLE, MN 55337			
(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
0 250	Continued From page 5 subcontract. - I have examined this application and all attachments and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct, and complete. I will notify MDH, in writing, of any changes to this information as required. honest - I attest to have all required policies and procedures of Minn. Stat. chapter 144G and Minn. Rules chapter 4659 in place upon licensure and to keep them current as applicable. Page six was electronically signed by authorized agent on November 22, 2022. The licensee had an assisted living license issued on February 1, 2023, with an expiration date of January 31, 2024. The licensee failed to ensure the following policies and procedures were developed and/or implemented: (1) conducting and handling background studies on employees; (2) orientation, training, and competency evaluations of staff. (3) conducting initial evaluations of residents' needs and the providers' ability to provide those services; (4) conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other	0 250			

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0 250	Continued From page 6 health care providers as appropriate; (5) conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards; (6) medication and treatment management; (7) delegation of tasks by registered nurses or licensed health professionals; As a result of this survey, the following orders were issued 0660, 1290, 1420, 1610, 1700, 1730, 1750, 1760, 1790, and 1910 indicating the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.08 to 144G.95. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 250			
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a	0 480			

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0 480	Continued From page 7 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated January 3, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480			
0 485 SS=C	144G.41 Subdivision 1. (13)(i)(A)and(C) Minimum Requirements (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: (A) menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes; and (C) the facility cannot require a resident to include and pay for meals in their contract; (ii) weekly housekeeping; (iii) weekly laundry service;	0 485			

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0 485	Continued From page 8 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide a menu one week in advance that was made available to all residents. 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: On January 2, 2024, at 1:10 p.m. no menu posting was observed. Unlicensed personnel/house manager (ULP/HM)-D stated the menu was not posted or given to residents as the meals were "changing all the time" and customizable to each resident's likes and dislikes. On January 2, 2024, at 1:24 p.m. licensed assisted living director (LALD)-E stated the menu was not posted and should be. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 485			
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a	0 660			

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0 660	Continued From page 9 comprehensive tuberculosis infection control 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 observation, interview, and record review, the licensee failed to maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) including documentation of completion of a two-step TST (tuberculin skin test) or other evidence of TB screening such as a blood test for one of one employee (unlicensed personnel (ULP)-F). This had the potential to 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, 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).	0 660			

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0 660	Continued From page 10 The findings include: The licensee's TB risk assessment dated August 1, 2021, (identified by licensed assisted living director (LALD)-E as an erroneous date indicating it should read August 1, 2023), identified the licensee was a low risk. ULP-F was hired September 4, 2023, to provide direct care services. On January 3, 2024, at 8:15 a.m. ULP-F was observed to administer medications to R3. ULP-F's employee record contained a TB symptom and history screening dated September 2, 1993, and a notation from physician dated January 27, 2021 (more than 2.5 years prior to hire), identifying ULP-F did not have signs or symptoms of active TB infection. The note further identified a chest x-ray from January 27, 2021, showed no evidence for active TB infection. ULP-F's employee record lacked documented evidence of a completed two-step tuberculin skin test (TST) or Interferon Gamma Release Assay (IGRA - a blood test used to see whether a person has been infected with the bacteria causing TB). On January 4, 2024, at 2:25 p.m. clinical nurse supervisor (CNS)-B stated ULP-F's TB symptom screen was most likely misdated for 1993 and should have been dated 2023. In addition, ULP-F should have had a new blood test and chest x-ray upon hire since documentation provided had been greater than 90 days prior to hire. The licensee's 8.16 Tuberculosis Screening dated August 1, 2021, identified staff whose essential	0 660			

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0 660	Continued From page 11 job functions require work within the same air space of home care clients will be screened and tested for tuberculosis prior to the staff being exposed to clients. The Minnesota Department of Health, Regulations for Tuberculosis Control in Health Care Settings dated July 2013, and based on CDC guidelines, noted: Baseline TB screening is required for all health care workers (HCWs) (Table 3.1). Baseline TB screening consists of three components: 1. Assessing for current symptoms of active TB disease, 2. Assessing TB history, and 3. Testing for the presence of infection with Mycobacterium tuberculosis by administering either a two-step TST or single IGRA. An employee may begin working with patients after a negative TB symptom screen (i.e., no symptoms of active TB disease) and a negative IGRA or TST (i.e., first step) dated within 90 days before hire. The second TST may be performed after the HCW starts working with patients. 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	0 680			

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0 680	Continued From page 12 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 emergency exit diagrams on each floor, have a written EP plan with all the required content, and practice and document testing of its emergency preparedness (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 or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents).	0 680			

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0 680	Continued From page 13 The findings include: POST EMERGENCY EXIT DIAGRAMS During a tour of the facility on January 2, 2024, at 1:00 p.m., the surveyor observed no emergency exit diagrams in the lower level (basement) of the licensee's building. On January 2, 2024, at 3:00 p.m. licensed assisted living director (LALD)-E stated the licensee lacked exit diagrams on each floor as required. EMERGENCY PREPAREDNESS PLAN CONTENT The licensee's emergency preparedness plan consisted of several documents and policies in a white three-ringed binder dated reviewed December 1, 2023. The book included a risk assessment, a communication plan, and various policies/procedures. The licensee's plan lacked the following required content: -Policy/procedure to address sewage/waste disposal; -Policy/procedures to address the use of volunteers, including the process/role for integration; -Policy/procedure to address role of facility under a waiver declared by the Secretary in accordance with section 1135 of the Act; and -Communication plan that includes Minnesota Office of Ombudsman for Long-Term Care. EP PLAN TESTING The licensee's EP plan included documentation of an analysis and response from a tabletop scenario titled "Should I stay or Should I go"	0 680			

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0 680	Continued From page 14 dated September 12, 2023, in which six staff participated. However, the EP plan lacked evidence the facility had participated in an annual full-scale exercise that is community-based, conducted an annual individual facility-based functional exercise, or experienced an actual natural or man-made emergency that required activation of the emergency plan. On January 4, 2024, at 12:45 p.m. LALD-E stated the licensee's EP plan lacked the required above components and indicated he had misunderstood the emergency plan testing requirements. The licensee's 9.02 Disaster Planning and Emergency Preparedness policy dated August 1, 2021, noted [The Licensee] would post emergency exit diagrams on each floor of the facility. The licensee's 9.01 Emergency Preparedness Plan - Appendix Z Compliance policy dated August 1, 2021, noted [The Licensee's] EP plan would include policies and procedures designed to align with the LTC (long term care) requirements in Appendix Z. [The Licensee] will conduct, at minimum, two emergency preparedness drills every 12 months -that do not include required fire/evacuation drills. One annual exercise will be a full-scale community wide exercise. The second annual exercise will either be a second full-scale community-wide exercise, or a tabletop exercise focused on our assisted living setting. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			

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0 690	Continued From page 15	0 690			
0 690 SS=E	144G.43 Subdivision 1 Resident record (a) Assisted living facilities must maintain records for each resident for whom it is providing services. Entries in the resident records must be current, legible, permanently recorded, dated, and authenticated with the name and title of the person making the entry. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure entries in the resident's records were authenticated by the title of the person making the entry for two of two 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 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: R3 On January 3, 2024, at 8:15 a.m. unlicensed personnel (ULP)-F was observed to prepare and administer the following medications to R3: -amlodipine (antihypertensive) 5 milligrams (mg) -aripiprazole (antipsychotic) 5 mg -docusate sodium (stool softener) 100 mg -duloxetine (antidepressant) 30 mg -Lyrica (for nerve pain) 75 mg	0 690			

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0 690	Continued From page 16 -metformin (antidiabetic) 500 mg Immediately following the administration of medications, ULP-F was observed to document the administration in the electronic medication administration record (eMAR), save, and close. On January 3, 2024, at 8:25 a.m. ULP-F was observed to administer the following requested as needed (PRN) medications to R3: acetaminophen (mild to moderate pain relief) 1000 mg diclofenac (topical pain relief) 1% gel 3-5 grams Immediately following the administration of medications, ULP-F was observed to document the administration in the eMAR, save, and close. R3's printed eMAR dated January 1, 2024, through January 4, 2024, had a list of staff identified (that had administered medications) at the bottom of each page with name, title, and initials. The above medications ULP-F was observed to administer to R3 were recorded as administered by unlicensed personnel/house manager (ULP/HM)-D. R1 On January 3, 2024, at 9:17 a.m. ULP-F was observed to take R1's blood sugar. Following the procedure, ULP-F was observed to document the result of 104 milligram per deciliter (mg/dL) in R1's eMAR, save, and close. On January 3, 2024, at 9:28 a.m. ULP-F was observed to obtain R1's blood pressure, pulse, oxygen saturation, and administer the following medications: -aripiprazole 20 mg -aspirin (heart health supplement) 81 mg -bumetanide (diuretic) 2 mg -buspirone (antianxiety) 15 mg	0 690			

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0 690	Continued From page 17 -certavite (vitamin supplement) 1 tablet -famotidine (gastric acid reducer) 20 mg -ferrous sulfate (iron supplement) 325 mg -olanzapine (antipsychotic) 5 mg -isosorbide (widens blood vessels) 30 mg -metoprolol tartrate (antihypertensive) 25 mg -Lyrica 150 mg -senna (laxative) 8.6 mg -Spiriva (bronchodilator) handihaler 18 micrograms (mcg) -venlafaxine (antidepressant) 150 mg -vitamin D3 (supplement) 2000 international units (IU) Immediately following the administration of medications, ULP-F was observed to document the administration in the eMAR, save, and close. R1's printed eMAR dated January 1, 2024, through January 3, 2024, had a list of staff identified that had administered medications at the bottom of each page with name, title, and initials. The above medications ULP-F was observed to administer to R1 were recorded as administered by ULP/HM-D. On January 4, 2024, at 10:46 a.m. licensed assisted living director (LALD)-E stated each employee had their own login and password. LALD-E stated each employee should be logging in and out so correct name, title, and initials populate to ensure accurate documentation for each resident. The licensee's 2.38 Resident Record - Information and Content policy dated August 1, 2021, noted [The Licensee] would maintain accurate records for each resident receiving services. The policy noted: -All entries in the resident records must be current, legible, permanently recorded, dated,	0 690			

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0 690	Continued From page 18 and authenticated with the name and title of the person making the entry. The licensee's 7.22 Medication & Treatment Record - Documentation & Refusal policy dated August 1, 2021, noted [The Licensee] would create and maintain a correct and accurate medication and/or treatment /therapy records for each resident receiving medication assistance or administration and or treatments and therapies. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 690			
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and	0 780			

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0 780	Continued From page 19 (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that are interconnected so actuation of one alarm causes all alarms in the dwelling unit to actuate and failed to provide working smoke alarm in sleeping room and the immediate vicinity of the sleeping. This affected all staff and 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: On January 4, 2024, at 3:00 p.m., survey staff toured the facility with license assisted living director (LALD)-E. It was observed a smoke alarm was not installed in the resident's sleeping room #5 and immediately outside of sleeping room #5 on the lower level. It was also observed upon testing, the smoke alarm immediately outside of sleeping room #4 on the main level was not interconnected with the rest of the smoke alarms in the dwelling unit, so the actuation of one alarm would cause all alarms	0 780			

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0 780	Continued From page 20 to operate. During the interview on January 4, 2024, at 3:00 p.m., LALD-E stated the licensee failed to provide interconnected smoke alarms immediately outside of sleeping room #4 and a working smoke alarm in the resident's sleeping room #5. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780			
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. 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 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	0 800			

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0 800	Continued From page 21 failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On January 4, 2024, at 2:10 p.m., survey staff toured the facility with licensed assisted living director (LALD)-E. During the facility tour, survey staff observed the following items: In the back deck side of the building, it was observed the exterior wall paint was bubbled and peeled badly on a large portion of the wall. In the resident sleeping room #5 on the lower level, it was observed the egress window opening was obstructed by built-up leaves and dirt, and the window well was not maintained. The debris obstructed the egress window from opening fully. Outside of the egress exit door on the lower level, it was observed burnt cigarettes were disposed of in a plastic bottle. Cigarettes are disposed of without a proper disposal container, creating a possible fire hazard. On January 4, 2024, at 2:10 a.m., LALD-E stated the exterior wall was not in good repair, and the egress window opening in resident bedroom #5 was not well maintained. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800			
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The	0 810			

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0 810	Continued From page 22 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. (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 a fire safety and evacuation plan with the required elements, failed to provide required employee training on fire safety and evacuation, and failed to conduct required evacuation drills as required. This had	0 810			

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0 810	Continued From page 23 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, 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: EMERGENCY EVACUATION PLAN On January 4, 2024, at 2:10 p.m., survey staff toured the facility with license assisted living director (LALD)-E. During the facility tour, survey staff observed the following discrepancies in the posted emergency evacuation plan: The posted emergency evacuation plan did not show the location and number of resident rooms. The posted emergency evacuation plans were not accurate depictions of the egress route and did not match to the current layout of the resident rooms, indicated by the following observations: -Near the resident bedroom #4 on the main level, it was observed that the wall and door locations were not shown correctly in the posted evacuation plan. -In the living room on the main level, it was observed that the main egress exit door was not shown correctly in the posted evacuation plan. -Near the resident bedroom #5 on the lower level,	0 810			

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0 810	Continued From page 24 it was observed that the wall and door locations were not shown correctly in the posted evacuation plan. -Near the resident bedroom #9 on the lower level, it was observed that the wall and door locations were not shown correctly in the posted evacuation plan. During the interview on January 4, 2024, at 3:00 p.m., LALD-E stated the posted emergency evacuation plans needed to be updated to show the current locations of resident bedrooms and verified the plan did not show the number of resident rooms. On January 4, 2024, at 3:00 p.m., LALD-E provided documentation on the fire safety and evacuation plan (FSEP), fire safety and evacuation training for the facility, and fire safety and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The FSEP included the following discrepancies: The FSEP indicated residents should be evacuated to the safest exit or nearest set of smoke compartment doors away from fire and smoke. This facility was a residential home and did not contain any sort of smoke compartments or smoke compartment doors to contain fire and smoke. The FSEP indicated when the fire alarm is triggered, all fire doors on magnetic holders will automatically close to contain smoke and fire and residents are to remain behind these doors. The facility did not have any doors that are on magnetic door holders or doors that are rated for smoke and fire. The facility also did not have a	0 810			

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0 810	Continued From page 25 fire alarm system that supports the use of magnetic door holders. The FSEP indicated the system was wired directly to the fire station. The facility did not have a fire alarm system that supported the direct connection to the fire station. The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The FSEP was provided by a third-party consultant, and it was not updated to meet the facility-specific layout. The FSEP included the RACE (Remove, Alarm, Confine and Extinguish or Evacuate) acronym as the fire safety procedure and instructed staff to pull the nearest fire alarm, clear the exit corridor, and close fire doors in case of fire, but the facility did not have a fire alarm system, fire doors. During the interview on January 4, 2024, at 3:00 p.m., LALD-E stated the fire safety and evacuation plan was from a third-party provider and verified the facility needed to update the fire safety and evacuation plan, including the facility-specific fire safety protocols. TRAINING Record review of the available documentation indicated employees did not receive training twice per year after initial hire by lack of training records. During the interview on January 4, 2024, at 3:00 p.m., LALD-E stated the licensee provided annual training on the fire safety and evacuation plan to employees, but not twice per year after the initial hire, as required by statute. LALD-E confirmed	0 810			

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0 810	Continued From page 26 there was no further documented training for the staff on the fire safety and evacuation plan as required by statute. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810			
0 820 SS=G	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure physical facility elements did not constitute a distinct hazard to life. The licensee failed to provide a resident bedroom with the minimum window opening meeting the minimum state standard for egress. This affected the occupied resident in bedroom #6 on the lower level. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death,	0 820	This immediate correction order identified on January 4, 2024, had the immediacy removed on January 8, 2024, however non-compliance remained at an scope and level of G. This was confirmed by the licensee via email and approved by evaluation supervisor.		

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0 820	Continued From page 27 or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On January 4, 2024, at 2:10 p.m., survey staff toured the facility with the Licensed Assisted Living Director (LALD)-E. During the facility tour, survey staff observed the following items: It was observed that occupied resident bedroom #6 on the lower level did not have windows that met the minimum size requirements for egress escape. The clear openable area of the opened windows measured 36 inches in height and 16 inches in width, with a total openable area of 576 square inches. The windows did not meet the minimum requirements for opening width and did not meet the minimum requirements for total openable area. Egress windows in existing sleeping rooms must have a minimum openable width of 20 inches and minimum openable height of 20 inches with no less than 648 square inches total of openable area (4.5 square feet) for the window. Survey staff explained to LALD-E that at least one egress window in each bedroom must be provided to meet the minimum state standard for an egress window to be a complying bedroom for resident occupancy. LALD-E verbally confirmed the findings. On January 4, 2024, at 3:30 p.m., survey staff explained to LALD-E that an immediate correction order was issued for the above finding. LALD-E	0 820			

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0 820	Continued From page 28 acknowledged the above finding. No Further information was provided. TIME PERIOD FOR CORRECTION: Immediate.	0 820			
01290 SS=I	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 an employee 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 observation, interview, and record review, the licensee failed to ensure a background study was submitted and received in affiliation with the assisted living license for one of nine unlicensed personnel (ULP-H). This resulted in an immediate correction order on January 3, 2024. In addition, the licensee failed to ensure a background study was affiliated with the assisted living license six of six employees (ULP-F, ULP-G, ULP-J, ULP-K, ULP-L, and ULP-P).	01290			

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01290	Continued From page 29 This practice resulted in a level three violation (a violation that harmed a client/resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at 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: ULP-H was hired on September 14, 2023. ULP-H's employee record lacked evidence of a cleared background study through NETStudy as required. ULP-H was listed in the Department of Human Services (DHS) NETStudy under health facility identification (HFID) 33248 (a sister facility HFID) dated September 22, 2023, and October 13, 2023, however; the status of both listed 'separated' from that employment. On January 3, 2024, at 3:27 p.m. ULP-G stated ULP-H had been working independently with all residents in the facility last night as she had taken report and relieved him from his duties this morning. On January 3, 2024, at 3:51 p.m. licensed assisted living director (LALD)-E stated ULP-H had been working independently and lacked a background study. LALD-E stated ULP-H had missed his appointment for fingerprints and the licensee had was not aware it was missed. The licensee's 4.02 Background Studies policy dated August 1, 2021, indicated no employee	01290			

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01290	Continued From page 30 would provide direct services and have independent direct contact with any residents until acceptable result of the background study have been received. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate The immediacy was lifted on January 3, 2024; however, non-compliance remains at level 3/Widespread (I). Lack of Affiliation The licensee failed to ensure a background study was affiliated with the Assisted Living license HFID number (37548) for six of six employees (ULP-F, ULP-G, ULP-J, ULP-K, ULP-L, and ULP-P). ULP-F ULP-F was hired on September 4, 2023. On January 3, 2024, at 8:15 a.m. ULP-F was observed to administer medications to R3. ULP-F's employee record contained a background study dated September 22, 2023, affiliated with a separate location operated by the licensee's owner under HFID license 33248. ULP-F's employee record lacked evidence of a current, cleared background study affiliated with the licensee's current assisted living HFID license 37548. ULP-G ULP-G was hired on March 20, 2023. ULP-G was listed in the DHS NETStudy under	01290			

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01290	Continued From page 31 HFID 33248. ULP-G was not affiliated with HFID 37548 as required. ULP-J ULP-J was hired on March 10, 2023. ULP-J was listed in the DHS NETStudy under HFID 33248. ULP-J was not affiliated with HFID 37548 as required. ULP-K ULP-K was hired on June 13, 2023. ULP-K was listed in the DHS NETStudy under HFID 33248. ULP-K was not affiliated with HFID 37548 as required. ULP-L ULP-L was hired on April 13, 2023. ULP-L was listed in the DHS NETStudy under HFID 33248. ULP-L was not affiliated with HFID 37548 as required. ULP-P ULP-P was hired on June 21, 2022. ULP-P was listed in the DHS NETStudy under HFID 33248. ULP-P was not affiliated with HFID 37548 as required. On January 3, 2024, at 3:51 p.m. LALD-E stated [the licensee] hired and trained employees to work in multiple locations operated by the licensee's owner but had not affiliated to each separate location. On January 4, 2024, the immediacy was removed based on observations by the surveyor and record reviews by the evaluation supervisor;	01290			

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01290	Continued From page 32 however, non-compliance remains at a scope and level of (I). No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290			
01420 SS=D	144G.62 Subd. 2 Delegation of assisted living services (b) When the registered nurse or licensed health professional delegates tasks to unlicensed personnel, that person must ensure that prior to the delegation the unlicensed personnel is trained in the proper methods to perform the tasks or procedures for each resident and is able to demonstrate the ability to competently follow the procedures and perform the tasks. If the unlicensed personnel has not regularly performed the delegated assisted living task for a period of 24 consecutive months, the unlicensed personnel must demonstrate competency in the task to the registered nurse or appropriate licensed health professional. The registered nurse or licensed health professional must document instructions for the delegated tasks in the resident's record. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted training and competency evaluations for one of one unlicensed personnel (ULP-F) who performed blood pressure monitoring. This practice resulted in a level two violation (a violation that did not harm a resident's health or	01420			

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NAME OF PROVIDER OR SUPPLIER MIDWEST RESIDENTIAL INC		STREET ADDRESS, CITY, STATE, ZIP CODE 421 HEMLOCK DRIVE BURNSVILLE, MN 55337			
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01420	Continued From page 33 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-F was hired September 4, 2023, to provide direct care services. On January 3, 2024, at 9:17 a.m., the surveyor observed ULP-F perform blood pressure monitoring on R1 using an automatic digital blood pressure machine. ULP-F obtained a reading of 172/153 millimeters of mercury (mmHg). R1's electronic medication administration record (eMAR) included: Blood Pressure and Pulse, take blood pressure and pulse twice daily and record. Inform nurse if blood pressure is above 180/90 mmHg or below 90/50 mmHg. On January 3, 2024, at 10:19 a.m. the surveyor asked ULP-F about R1's blood pressure result. After the surveyor prompted ULP-F that the recorded reading was above parameters, ULP-F told unlicensed personnel/house manager (ULP/HM)-D. ULP-F did not notify the nurse. On January 3, 2024, at 10:20 a.m. ULP/HM-D instructed ULP-F to "wait for an hour and retake it". ULP/HM-D stated she would notify the nurse if the next reading did not decrease. On January 3, 2024, at 11:44 a.m. ULP-F was observed to retake R1's blood pressure using an automatic digital blood pressure machine. ULP-F	01420			

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01420	Continued From page 34 obtained a reading of 109/69 mmHg. ULP-F's employee record lacked evidence ULP-F had been trained by a RN and demonstrated they were competent to perform blood pressure monitoring. On January 3, 2024, at 1:04 p.m., clinical nurse supervisor (CNS)-B stated R1's blood pressure reading of 172/153 was "extremely high" and should have been reported to the nurse as per the instructions. On January 4, 2024, at 2:25 p.m. CNS-B stated ULP-F's employee recorded lacked documentation to indicate ULP-F had been trained by a RN and demonstrated they were competent to perform blood pressure monitoring. The American Heart Association healthy and unhealthy blood pressure ranges dated May 30, 2023, identified a normal blood pressure reading of less than 120/80 mmHg. The licensee's 7.15 Medication & Treatment - Administration & Delegation policy dated August 1, 2021, indicated when administration of medications or treatment/therapy is delegated or assigned to ULP, the registered nurse would instruct the ULP in the proper methods with respect to each resident to administer the medications or perform treatment/therapy, and the ULP has demonstrated the ability to competently follow the procedures. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01420			

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01610	Continued From page 35	01610			
01610 SS=D	144G.70 Subd. 2 (a-b) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan 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. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a registered nurse (RN) conducted an initial assessment for one of one resident (R1) prior to initiation of services. 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).	01610			

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01610	Continued From page 36 The findings include: R1 was admitted on August 12, 2023, and received services under the licensee's assisted living license. R1's diagnoses included muscle weakness, morbid obesity, bipolar disorder (mental illness causing extreme mood swings from high to low), and diabetes. R1's Service Agreement dated January 3, 2024, indicated services included assistance with grooming, bathing, dressing, transferring, and administration of medications and treatments per physician orders. R1's record included a 6.04 Uniform Assessment Tool dated August 17, 2023. No assessment was completed prior to or upon initiation of services on August 12, 2023. On January 4, 2024, at 2:25 p.m. clinical nurse supervisor (CNS)-B stated R1's admission assessment was not completed upon admission. CNS-B indicated she thought she had 14 days to complete the initial assessment. The licensee's 6.01 Assessments, Review & Monitoring policy dated August 1, 2021, noted: [The Licensee] would conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan 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. No further information was provided.	01610			

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01610	Continued From page 37	01610			
01640 SS=F	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 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 interview and record review, the licensee failed to ensure the service plan included a signature or other authentication by the resident and the facility to document agreement on the services to be provided for one of one resident (R1).	01640			

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01640	Continued From page 38 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1's diagnoses included muscle weakness, morbid obesity, bipolar disorder (mental illness causing extreme mood swings from high to low), and diabetes. R1's Service Agreement dated January 3, 2024, indicated services included assistance with grooming, bathing, dressing, transferring, and administration of medications and treatments per physician orders; however, the service plan lacked a signature or other authentication by the facility and the resident/resident's representative, documenting agreement on the services to be provided. On January 4, 2024, at 2:25 p.m. clinical nurse supervisor (CNS)-B stated she developed the service plan as part of the initial assessment. CNS-B stated once that is done, she is supposed to print the service plan and have the resident sign it, but she does not have access to print in the facility. CNS-B stated none of the current residents have service plans signed by the resident or the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	01640			

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01640	Continued From page 39 (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, 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 one of one resident (R1).	01650			

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01650	Continued From page 40 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: R1's diagnoses included muscle weakness, morbid obesity, bipolar disorder (mental illness causing extreme mood swings from high to low), and diabetes. R1's Service Agreement dated January 3, 2024, indicated services included assistance with grooming, bathing, dressing, transferring, and administration of medications and treatments per physician orders. The service plan lacked: - the fees for services. On January 4, 2024, at 11:00 a.m., licensed assisted living director (LALD)-E stated the service plan lacked the above required content. In addition, LALD-A stated the same format was utilized for all residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650			
01700 SS=F	144G.71 Subd. 2 Provision of medication management services	01700			

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01700	Continued From page 41 (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted a face-to-face medication management assessment to include all required content for one of one resident (R1) prior to providing medication management services. This practice resulted in a level two violation (a violation that did not harm a resident's health or	01700			

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01700	Continued From page 42 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on January 2, 2023, at 11:30 a.m. licensed assisted living director (LALD)-E and licensed practical nurse (LPN)-C stated the licensee provided medication management services to their residents. R1's diagnoses included muscle weakness, morbid obesity, bipolar disorder (mental illness causing extreme mood swings from high to low), and diabetes. R1's Service Agreement dated January 3, 2024, indicated services included assistance with administration of medications and treatments per physician orders. R1's Physician Orders dated December 28, 2023, included two antipsychotics, one inhaler, one antidepressant, one diuretic, one antianxiety, one laxative, one muscle relaxant, one for gastric reflux, one for cholesterol, three insulins, one for blood pressure, three for pain, one to prevent chest pain, one for allergies, and five supplements. On January 3, 2024, at 9:28 a.m. unlicensed personnel (ULP)-F was observed to administer medications to R1. R1 began receiving services from the licensee on	01700			

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01700	Continued From page 43 August 12, 2023. R1's record indicated a medication management assessment was completed on August 18, 2023, (six days after the start of services). On January 4, 2024, at 2:25 p.m. clinical nurse supervisor (CNS)-B stated R1 began receiving medication administration services on R1's admission date of August 12, 2023. CNS-B further stated a medication management assessment with all required components, had not been completed until August 18, 2023, indicating she thought she had 14 days to complete it. The licensee's 7.01 Medication Management - Assessment, Monitoring & Reassessment policy dated August 1, 2021, identified prior to providing medication management services, [The Licensee] would provide an assessment by a registered nurse (RN) to determine what medication management services would be provided and how they would be implemented. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01700			
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for	01730			

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01730	Continued From page 44 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 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 registered nurse (RN) developed an individualized medication management plan to	01730			

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01730	Continued From page 45 include all required content for one of one resident (R1) prior to providing medication management services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on January 2, 2023, at 11:30 a.m., licensed assisted living director (LALD)-E and licensed practical nurse (LPN)-C stated the licensee provided medication management services to their residents. R1's diagnoses included muscle weakness, morbid obesity, bipolar disorder (mental illness causing extreme mood swings from high to low), and diabetes. R1's Service Agreement dated January 3, 2024, indicated services included assistance with administration of medications and treatments per physician orders. R1's Physician Orders dated December 28, 2023, included two antipsychotics, one inhaler, one antidepressant, one diuretic, one antianxiety, one laxative, one muscle relaxant, one for gastric reflux, one for cholesterol, three insulins, one for blood pressure, three for pain, one to prevent chest pain, one for allergies, and five supplements.	01730			

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01730	Continued From page 46 On January 3, 2024, at 9:28 a.m. unlicensed personnel (ULP)-F was observed to administer medications to R1. R1 began receiving services from the licensee on August 12, 2023. R1's record indicated a medication management assessment was completed on August 18, 2023 (six days after the start of services). On January 4, 2024, at 2:25 p.m. clinical nurse supervisor (CNS)-B stated R1 began receiving medication administration services on her admission date of August 12, 2023. CNS-B further stated a medication management plan with all required components, had not been completed until August 18, 2023, further indicating she thought she had 14 days to complete it. The licensee's 7.03 Medication Management Individualized Plan policy dated August 1, 2021, identified for each resident with medication management services, [The Licensee] would develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: -A statement describing the medication management services that will be provided; -A description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; -Documentation of specific resident instructions relating to the administration of medications; -Identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis;	01730			

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01730	Continued From page 47 -Identification of medication management tasks that may be delegated to unlicensed personnel; -Procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and -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. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730			
01750 SS=E	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure delegated procedures were followed by one of one	01750			

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01750	Continued From page 48 unlicensed personnel (ULP-F) observed during medication administration with two 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 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: R3 R3's diagnoses included hypertension (high blood pressure), fusion of spine (surgery that joins two or more bones to form one solid bone), osteoarthritis (joint pain, stiffness, and loss of flexibility in affected area), schizoaffective disorder (mental disorder with abnormal thought processes and an unstable mood). R3's Service Agreement dated January 4, 2024, indicated services included administration of medications and treatments. R3's physician orders dated December 28, 2023, included an order for diclofenac gel (topical non-steroidal anti-inflammatory drug for arthritis discomfort) 1% apply 3-5 grams to neck, back, or joints twice daily as needed for pain. On January 3, 2024, at 11:25 a.m. R3 requested his "gel" for pain. ULP-F washed her hands, grabbed a pair of gloves, R3's diclofenac 1% gel, and went to R3's room. ULP-F was observed to	01750			

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01750	Continued From page 49 apply four separate pea sized amounts of gel to R3's low back, neck, and right forearm. When ULP-F was asked how she measured the amount of diclofenac 1% gel, she indicated she used her middle finger distal phalanx joint. On January 3, 2024, at 12:57 p.m. clinical nurse supervisor (CNS)-B stated diclofenac gel should be administered according to manufacturer's recommendations and she would need to obtain a dosing card from the pharmacy. In addition, CNS-B stated R3's diclofenac order did not have clear parameters. Diclofenac sodium topical gel 1% instructions for use revised February 2020, noted: Use the dosing card to correctly measure each dose of diclofenac sodium topical gel. To measure the correct amount of diclofenac sodium topical gel, place the dosing card on a flat surface so that you can read the print. Squeeze the diclofenac sodium topical gel onto the dosing card evenly, up to the prescribed amount. R1 R1's diagnoses included muscle weakness, bipolar disorder (mental illness causing extreme mood swings from high to low), and diabetes. R1's Service Agreement dated January 3, 2024, indicated services included administration of medications and treatments per physician orders. R1's Physician Orders dated December 28, 2023, included NovoLog (fast-acting insulin) FlexPen 100 units/milliliter (ml), check blood sugar before meals and inject units subcutaneously per sliding scale: if 151-200=3 units, 201-250=4 units, 251-300=5 units, 301-350=6 units, 351-400=7 units, 401-450=8 units, greater than 450 call	01750			

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01750	Continued From page 50 physician. On January 3, 2024, at 12:27 p.m. ULP-F was observed to take R1's blood sugar and obtained a result of 185 milligram per deciliter (mg/dL). ULP-F stated R1 would require insulin when it was closer in time for R1 to eat lunch. On January 3, 2024, at 1:35 p.m. (after R1 had ate lunch) ULP-F obtained R1's NovoLog FlexPen from the medication cabinet, removed the cap, cleansed the hub, applied a new needle, and dialed the pen to three units. ULP-F then administered the insulin in R1's left upper arm. ULP-F did not prime the insulin pen and waste two units of insulin. When ULP-F was asked about wasting two units, ULP-F stated she was not aware of that step. On January 3, 2024, at 1:45 p.m. CNS-B stated insulin should be administered according to manufacturer's recommendations and stated staff were trained to prime the insulin pen and waste two units prior to the ordered insulin injection amount. NovoLog FlexPen Instructions for use dated April 2015, instructed: Before each injection small amounts of air may collect in the cartridge during normal use. To avoid injecting air and to ensure proper dosing: Turn the dose selector to select 2 (two) units. -Hold your NovoLog FlexPen with the needle pointing up. Tap the cartridge gently with your finger a few times to make any air bubbles collect at the top of the cartridge. -Keep the needle pointing upwards, press the push-button all the way in. The dose selector returns to 0 (zero). -A drop of insulin should appear at the needle tip.	01750			

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01750	Continued From page 51 If not, change the needle and repeat the procedure no more than 6 (six) times. The licensee's 7.15 Medication & Treatment - Administration & Delegation policy dated August 1, 2021, indicated when administration of medications or treatment/therapy is delegated or assigned to unlicensed personnel, [The Licensee] will ensure that the registered nurse has: 1. Instructed the ULP in the proper methods with respect to each resident to administer the medications or perform treatment/therapy, and the ULP has demonstrated the ability to competently follow the procedures. 2. Specified in writing specific instructions for each resident and documented those instructions in the resident's records 3. Communicated with the ULP about the individual needs of the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750			
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 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	01760			

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01760	Continued From page 52 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 as ordered for one of two residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's diagnoses included muscle weakness, morbid obesity, bipolar disorder (mental illness causing extreme mood swings from high to low), and diabetes. R1's Service Agreement dated January 3, 2024, indicated services included administration of medications and treatments per physician orders. R1's Physician Orders dated December 28, 2023, included orders for: -nystatin cream (topical antifungal) 100,000 units/gram apply topically under breast area twice daily until resolved, then change to twice daily as needed (PRN). R1's electronic medication administration record	01760			

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01760	Continued From page 53 (eMAR) dated January 2024, included an order for nystatin cream (topical antifungal) 100,000 units/gram apply topically under breast area twice daily until resolved, then change to twice daily as needed. The eMAR further included: wound care to right buttock-clean the wound apply barrier cream, cover with a 4x4 taped into place. On January 3, 2024, at 10:32 a.m. the surveyor observed ULP-F and ULP-G complete morning cares for R1. ULP-G brought a basin of water to the overbed table. R1 washed and dried her own face, then wearing gloves, ULP-F wet the washcloth and washed and dried under R1's axillary, breasts, abdominal folds, peri-area, and buttocks. ULP-F then applied nystatin cream under R1's breasts and right inner buttock area. ULP-F and ULP-G indicated the nystatin cream was applied because R3 had redness under her breasts and it was used on her buttock due to ongoing fragile and red skin that had been open. ULP-F further indicated the nystatin cream was barrier cream. ULP-F then applied a 4x4 gauze pad to R1's right buttock area, applied an incontinent garment, and ULP-F and ULP-G continued to complete R1's morning cares. Following the completion of cares, ULP-F documented she had applied barrier cream to R1's right buttock (not the nystatin cream as observed) and did not document the administration of the nystatin cream under breasts. On January 3, 2024, at 1:14 p.m. clinical nurse supervisor (CNS)-B stated the ULP should have followed the orders as reflected on the eMAR and documented the administration of nystatin cream under R1's breasts. CNS-B further noted nystatin cream was not barrier cream and should not have been applied to R1's buttock.	01760			

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01760	Continued From page 54 The licensee's 7.42 Topical Application of Ointment & Cream policy dated August 1, 2021, noted: 1. Medications always need to be administered according to the "6 Rights" -Right person -Right medication -Right time -Right route -Right dose -Right chart/record to document that the medication was taken. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760			
01790 SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may	01790			

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01790	Continued From page 55 delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the	01790			

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01790	Continued From page 56 doses of each returned medication. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) trained and ensured competency for one of one unlicensed personnel (ULP-F) providing medications to residents for unplanned time away from home when the licensed nurse was not available. 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 included: ULP-F was hired to provide direct care to the licensee's residents on September 4, 2023. ULP-F's employee record lacked documentation of training and competencies for providing medications for unplanned time away when the RN was not available. On January 4, 2024, at 2:25 p.m., clinical nurse supervisor (CNS)-B stated there was a process for ULP to follow, but did not complete competency testing to staff preparing medications for residents with unplanned time away. CNS-B further added staff would have the potential of needing to do this task when a nurse was not available.	01790			

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01790	Continued From page 57 The licensee's 7.10 Medication Management - Planned & Unplanned Time Away policy dated August 1, 2021, noted for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or properly trained and competency tested unlicensed personnel may give the resident or resident's representative medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven days. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790			
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other	01910			

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01910	Continued From page 58 individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document in the resident's record the disposition of the medication including the date as applicable, for one of one discharged resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: The licensee's discharged or deceased resident roster dated January 2, 2024, indicated R2 discharged on July 17, 2023. R2's Discharge Summary identified R2 was admitted to the hospital July 13, 2023, and from then discharged to a hospice facility on July 17, 2023. R2's record included a Medication Disposal Log that included columns to identify the date, medication/prescription number (RX #), amount, disposal method, nurse signature, and witness signature. The following medication was listed without a disposal date: - Morphine sulfate ER (schedule II opioid analgesic). On January 4, 2024, at 2:25 p.m. clinical nurse supervisor (CNS)-B stated [The Licensee]	01910			

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01910	Continued From page 59 provided medication management services for R2. CNS-B further stated a date was required with each medication disposal and should have been included on R2's medication disposal log for Morphine sulfate ER. The licensee's 7.23 Medication Disposal policy dated August 1, 2021, included: upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, date of disposition, and names of staff and other individuals involved in the disposition. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910			
02310 SS=D	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to ensure oxygen cylinders were secured in a rack to prevent tipping or damage for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	02310			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37548	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/04/2024
NAME OF PROVIDER OR SUPPLIER MIDWEST RESIDENTIAL INC		STREET ADDRESS, CITY, STATE, ZIP CODE 421 HEMLOCK DRIVE BURNSVILLE, MN 55337			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
02310	Continued From page 60 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 January 3, 2024, at 9:17 a.m. the surveyor observed one large stationary oxygen tank and four portable oxygen cylinders sitting on the floor alongside of R1's dresser, unsecured. On January 3, 2024, at 11:00 a.m. unlicensed personnel/house manager (ULP/HM)-D stated the oxygen tanks have always been kept there. ULP/HM-D indicated the oxygen cylinders could be easily tipped over. On January 3, 2024, at 1:04 p.m. clinical nurse supervisor (CNS)-B stated R1's oxygen cylinders were unsecured. CNS-B stated [The Licensee] did not have an oxygen rack or chains to secure the cylinders and would need to ask the oxygen company for something to secure them from falling over. The Minnesota Department of Health Oxygen Cylinder Storage Requirements dated April 16, 2020, indicated cylinders must be secured (chains or racks) to prevent them from falling over. No additional information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310			

Type: Full
Date: 01/03/24
Time: 15:38:54
Report: 1018241003

Food and Beverage Establishment Inspection Report

Page 1

Location:

Midwest Residential Inc
421 Hemlock Drive
Burnsville, MN55337
Dakota County, 19

Establishment Info:

ID #: 0037910
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6513152649
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 OBSERVED TO BE STORED OVER READY TO EAT FOODS IN THE COOLER.
CORRECTED ON SITE.

Corrected on Site

4-700 Sanitizing Equipment and Utensils

4-702.11 ** Priority 1 **

MN Rule 4626.0900 Sanitize utensils and food contact surfaces of equipment before use, after cleaning.
DISHWASHER IS CURRENTLY OUT OF ORDER SO ESTABLISHMENT IS WASHING DISHES BY HAND. DISHES ARE ONLY CURRENTLY GETTING WASHED AND RINSED AND NOT SANITIZED.
DISCUSSED ADDING SANITIZE STEP WITH ESTABLISHMENT.

Comply By: 01/04/24

Food and Equipment Temperatures

Process/Item: Cold Holding

Temperature: 40 Degrees Fahrenheit - Location: REFRIGERATOR

Violation Issued: No

Type: Full
Date: 01/03/24
Time: 15:38:54
Report: 1018241003
Midwest Residential Inc

Food and Beverage Establishment Inspection Report

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

ESTABLISHMENT IS A RESIDENTIAL HOME WITH RESIDENTIAL EQUIPMENT.

FLOORS, WALLS AND CEILINGS WERE OBSERVED TO BE IN GOOD CONDITION DURING THIS INSPECTION AND WILL BE MONITORED THROUGH THE YEARS.

ESTABLISHMENT DOES ALL SAME DAY SERVICE OF FOOD.

KITCHEN HAS A ONE BASIN SINK FOR DISH WASHING AND A SEPARATE SINK IN THE RESTROOM FOR HAND WASHING.

DISHWASHER IS CURRENTLY OUT OF ORDER.

DISCUSSED PEST CONTROL AND ILLNESS REPORTING. VIEWED ILLNESS LOG.

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 1018241003 of 01/03/24.

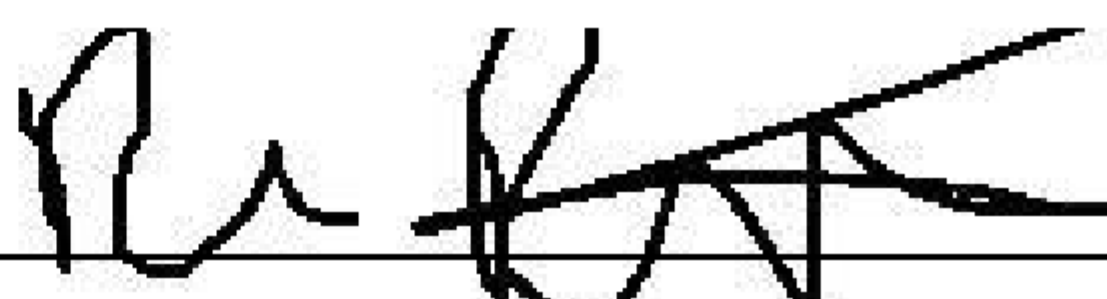
Certified Food Protection Manager: HIBO H KHALAF

Certification Number: FM115951 Expires: 02/24/26

Inspection report reviewed with person in charge and emailed.

Signed: _____

Establishment Representative

Signed:  _____

Rebecca Prestwood

Sanitarian 3

6512013777

rebecca.prestwood@state.mn.us