Electronically Delivered

February 10, 2023

Licensee
Heartwood
500 Heartwood Drive
Crosby, MN 56441

RE: Project Number(s) SL26228015

Dear Licensee:

The Minnesota Department of Health completed an evaluation on January 25, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

The correction order documentation should include the following:

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

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

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

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

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

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

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

Sincerely,

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

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26228	A. BUILDING: _____ B. WING _____	01/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTWOOD	500 HEARTWOOD DRIVE CROSBY, MN 56441

(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(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: SL26228015-0 On January 23, 2023, through January 25, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 100 residents; 46 of whom received services under the provider's Assisted Living with Dementia license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living 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.	
0 130 SS=C	144G.12, Subd. 1 Application for Licensure Each application for an assisted living facility license, including provisional and renewal	0 130		

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0 130	Continued From page 1 applications, must include information sufficient to show that the applicant meets the requirements of licensure, including: (1) the business name and legal entity name of the licensee, and the street address and mailing address of the facility; (2) the names, e-mail addresses, telephone numbers, and mailing addresses of all owners, controlling individuals, managerial officials, and the assisted living director; (3) the name and e-mail address of the managing agent and manager, if applicable; (4) the licensed resident capacity and the license category; (5) the license fee in the amount specified in section 144.122; (6) documentation of compliance with the background study requirements in section 144G.13 for the owner, controlling individuals, and managerial officials. Each application for a new license must include documentation for the applicant and for each individual with five percent or more direct or indirect ownership in the applicant; (7) evidence of workers' compensation coverage as required by sections 176.181 and 176.182; (8) documentation that the facility has liability coverage; (9) a copy of the executed lease agreement between the landlord and the licensee, if applicable; (10) a copy of the management agreement, if applicable; (11) a copy of the operations transfer agreement or similar agreement, if applicable; (12) an organizational chart that identifies all organizations and individuals with an ownership interest in the licensee of five percent or greater and that specifies their relationship with the	0 130		

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0 130	Continued From page 2 licensee and with each other; (13) whether the applicant, owner, controlling individual, managerial official, or assisted living director of the facility has ever been convicted of: (i) a crime or found civilly liable for a federal or state felony level offense that was detrimental to the best interests of the facility and its resident within the last ten years preceding submission of the license application. Offenses include: felony crimes against persons and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pretrial diversions; financial crimes such as extortion, embezzlement, income tax evasion, insurance fraud, and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pretrial diversions; any felonies involving malpractice that resulted in a conviction of criminal neglect or misconduct; and any felonies that would result in a mandatory exclusion under section 1128(a) of the Social Security Act; (ii) any misdemeanor conviction, under federal or state law, related to: the delivery of an item or service under Medicaid or a state health care program, or the abuse or neglect of a patient in connection with the delivery of a health care item or service; (iii) any misdemeanor conviction, under federal or state law, related to theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service; (iv) any felony or misdemeanor conviction, under federal or state law, relating to the interference with or obstruction of any investigation into any criminal offense described in Code of Federal Regulations, title 42, section 1001.101 or 1001.201;	0 130		

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0 130	Continued From page 3 (v) any felony or misdemeanor conviction, under federal or state law, relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance; (vi) any felony or gross misdemeanor that relates to the operation of a nursing home or assisted living facility or directly affects resident safety or care during that period; (vii) any revocation or suspension of a license to provide health care by any state licensing authority. This includes the surrender of such a license while a formal disciplinary proceeding was pending before a state licensing authority; (viii) any revocation or suspension of accreditation; or (ix) any suspension or exclusion from participation in, or any sanction imposed by, a federal or state health care program, or any debarment from participation in any federal executive branch procurement or nonprocurement program; (14) whether, in the preceding three years, the applicant or any owner, controlling individual, managerial official, or assisted living director of the facility has a record of defaulting in the payment of money collected for others, including the discharge of debts through bankruptcy proceedings; (15) the signature of the owner of the licensee, or an authorized agent of the licensee; (16) identification of all states where the applicant or individual having a five percent or more ownership, currently or previously has been licensed as an owner or operator of a long-term care, community-based, or health care facility or agency where its license or federal certification has been denied, suspended, restricted, conditioned, refused, not renewed, or revoked under a private or state-controlled receivership,	0 130		

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0 130	Continued From page 4 or where these same actions are pending under the laws of any state or federal authority; (17) statistical information required by the commissioner; and (18) any other information required by the commissioner. This MN Requirement is not met as evidenced by: Based on interview and record review the facility failed to include their independent living resident capacity during transition to an assisted living license to meet the requirements of licensure. This had the potential to affect all 100 residents, staff, and visitors. 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). Findings include: The licensee's Application for Assisted Living License, signed by the authorized agent (AA)-J on May 19, 2022, identified an application for a secured dementia care unit and a building total licensed resident capacity for 55 residents. On January 25, 2023, at 9:40 a.m., licensed assisted living director (LALD)-A stated the licensee's total current census was 100 residents, 11 in memory care, 35 in assisted living, and 54 independent residents. On January 25, 2023, at 2:55 p.m., administrator	0 130		

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0 130	Continued From page 5 (A)-B stated they were not aware the independent residents also needed to be included in the total census used for licensing. No further information provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 130		
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: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This had the potential to affect all residents. This practice resulted in a level two violation (a	0 480		

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0 480	Continued From page 6 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 included document titled, Food and Beverage Establishment Inspection Report dated January 24, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
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, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation regarding the health, safety, comfort, and well-being of the residents. This deficient condition had the potential to affect all staff, residents, and visitors.	0 800		

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0 800	Continued From page 7 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). Findings include: On a facility tour on January 25, 2023, at approximately 11:15 a.m. with administrator (A)-B and facilities manager (FM)-I, it was observed the documentation for the required annual servicing of the kitchen hood fire suppression system indicated the service was past due. These deficient conditions were visually verified by A-B and FM-I accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement,	0 810		

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0 810	Continued From page 8 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 a record review and interview, the licensee failed to develop a fire safety and evacuation plan with required elements, failed to provide required employee and resident training on fire safety and evacuation, and failed to conduct the required evacuation drills. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when	0 810		

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0 810	Continued From page 9 problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). A record review and interview were conducted on January 25, 2023, at approximately 10:15 a.m. of documents provided by administrator (A)-B, executive director of facilities maintenance (EDM)-G and facilities manager (FM)-I on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. Findings include: Record review of the available documentation indicated that the licensee did not maintain the fire safety and evacuation plan for the facility as follows: Record review of the available documentation indicated part of the building floor plan for evacuation did not include resident room numbers. Record review of the available documentation indicated that the fire safety and evacuation plan did not include fire protection procedures for residents in the event of a fire or similar emergency. The documentation provided was not included as part of the plan it was a separate document. Record review of the available documentation indicated that the fire safety and evacuation plan did not include procedures for employees regarding resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation.	0 810		

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0 810	Continued From page 10 Record review of the available documentation indicated that employees did not receive training on the facility fire safety and evacuation plan upon initial hire and twice per year thereafter. Record review of the available documentation indicated that the licensee did not provide training at least once per year to residents who are capable of self-evacuation on the proper actions to be taken in the event of a fire regarding movement, evacuation, and relocation. Record review of the available documentation did not indicate that evacuation drills had been conducted twice per year per shift and at least once every other month as required. All deficiencies were verified by A-B, EDM-G and FM-I during the interview at approximately 10:45 a.m. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
0 970 SS=C	144.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by:	0 970		

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0 970	Continued From page 11 Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the facility's liability for health, safety, or personal property of a resident. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: During the entrance conference on January 23, 2023, at 10:50 a.m., the evaluator asked for a copy of the licensee's assisted living (AL) residency agreement, The (AL) residency agreement was provided and later reviewed by the surveyor. The assisted living contract included three clauses that indicated the resident would waive the facility's liability for health, safety, or personal property of a resident. Responsibilities of Resident, Page 15, section 7: "Resident to be responsible for the costs associated with the following, caused by the acts or failure of resident, pets, ... whether intentional or unintentional, and whether or not under the resident's control or direction: 1) any loss, property damage, or repair or service (including plumbing problems) or injury to any person". Personal Property, Page 18, section 8 (c):	0 970		

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0 970	Continued From page 12 "Resident assumes primary responsibility for all risk for harm to or loss of any of resident's personal property". Other Losses or Damages, Page 18, section 8 (c): "Resident acknowledges familiarity with the apartment, the premises and services of the community and is therefore willing to, and does, assume the risks associated with occupancy. Resident further acknowledges that neither owner nor any of its affiliates is an insurer of resident's safety". On January 25, 2023, at 12:15 p.m., licensed assisted living director (LALD)-A, reviewed the AL Residency Agreement containing the sections noted above and stated she would have to look further into the language used in the AL Resident Agreement. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 970		
01290 SS=F	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	01290		

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	26228	A. BUILDING: _____ B. WING _____	01/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTWOOD	500 HEARTWOOD DRIVE CROSBY, MN 56441

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01290	Continued From page 13 reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a background study was submitted and clearance was received in affiliation with the assisted living with dementia care license for three of three employees, unlicensed personnel [(ULP)-C, ULP-D] and licensed practical nurse (LPN)-E. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-C ULP-C was hired on December 12, 2014, to provide direct care services to licensee's residents under the comprehensive license and continued to provide direct care after August 1, 2021, under the assisted living license. ULP-C's employee record contained a background study, submitted by a separate location operated by the same corporation dated December 15, 2014. ULP-C's employee record lacked evidence the licensee submitted a background study for their license.	01290		

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01290	Continued From page 14 ULP-D ULP-D was hired on March 21, 2016, to provide direct care services to licensee's residents under the comprehensive license and continued to provide direct care after August 1, 2021, under the assisted living license. ULP-D's employee record contained a background study, submitted by a separate location operated by the same corporation dated January 21, 2016. ULP-D's employee record lacked evidence the licensee submitted a background study for their license. LPN-E LPN-E was hired on September 28, 2015, to provide supervisory and direct care services to licensee's staff and residents. LPN-E continued to provide supervisory and direct care services after August 1, 2021, under the assisted living license. LPN-E's employee record contained a background study, submitted by a separate location operated by the same corporation dated January 21, 2016. LPN-E's employee record lacked evidence the licensee submitted a background study for their license. On January 24, 2023, at 11:37 a.m., licensed assisted living director (LALD)-A stated licensee is co-owned by the medical center listed on the background checks, however, background studies of non-management staff had not been affiliated with the licensee. The licensee's Criminal Background Check Requirements policy dated December 14, 2022, indicated licensee would assure criminal background checks were conducted as required by law and regulation.	01290		

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01290	Continued From page 15 No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed ongoing resident reassessments	01620		

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01620	Continued From page 16 for three of three residents (R2, R3, R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: R2 R2's diagnoses included epilepsy and major depressive disorder. R2's service agreement dated October 1, 2022, indicated R2 was receiving services to include escorts, meals, medication administration, shower assist, laundry and housekeeping. R2's record included 90-day clinical updates dated April 5, 2022, June 30, 2022, and September 28, 2022 which were completed by the RN. The 90-day clinical update dated December 19, 2022 was completed by licensed practical nurse (LPN)-E. R3 R3's diagnoses included diabetes mellitus type 2 and hypertension. R3's service agreement dated April 8, 2022, indicated R3 was receiving services to include daily homemaking and recording weight. R3's record included 90-day clinical updates dated February 21, 2022, May 23, 2022, and August 18, 2022 which were completed by the	01620		

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01620	Continued From page 17 RN. The 90-day clinical update dated November 17, 2022 was completed by the LPN-E. R4 R4's diagnoses included cerebral vascular accident, seizure disorder, and depression. R4's Service Agreement dated April 5, 2022, indicated R4 was receiving services to inlcude medication monitoring, medical appointment scheduling, medication administration and record weight. R4's record included 90-day clinical updates dated April 4, 2022, June 30, 2022, September 28, 2022, December 27, 2022, which were completed by the RN. The 90-day clinical update dated January 6, 2022, was completed by LPN-E. On January 24, 2023, at 1:30 p.m., Licensed Assisted Living Director (LALD)-A stated the licensee was not aware that with the assisted living 144G licensure change that occurred on August 1, 2021, LPNs were no longer able to complete every other 90-day assessment like the previous license for Comprehensive Home Care. LALD-A stated that all residents may have 90-day assessments that have been completed by LPN. The Licensee's MN AL Nursing Assessment policy last updated May 3, 2022, indicated the RN will complete the following nursing assessments of the resident's physical, mental, and cognitive needs as required: initial assessment, 14-day assessment, and ongoing assessment: completed periodically but no less than 90 days. No further information was provided. TIME PERIOD FOR CORRECTION:	01620		

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01620	Continued From page 18 Twenty-One (21) days	01620		
01770 SS=F	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure documentation of medication setup included all the required content for three of three residents (R7, R8, R9). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: During the entrance conference on January 23, 2023, at 10:30 a.m., licensed assisted living director (LALD)-A stated the licensee provided medication management services to include medication setup. During the entrance tour on January 23, 2023, at 12:04 p.m., LALD-A stated the unlicensed professional (ULP) do not administer insulin using the insulin pens. Licensed practical nurse (LPN)	01770		

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01770	Continued From page 19 on site draws the appropriate insulin dose into a syringe for administration. R7 R7's diagnoses included diabetes mellitus 2 (high blood sugar levels). R7's service plan dated August 2, 2022, indicated R7 received medication management services. R7's January 2023, electronic medication administration record (EMAR), included lispro insulin 100 units/milliliters (ml) insulin (lowers blood sugar), three (3) units with breakfast, one (1) unit with lunch and two (2) units with supper. R7's January 2023 EMAR indicated on January 24, 2023, lispro insulin 100 units/ml was discontinued and Novolog insulin 100 units/ml (lowers blood sugars) started, 3 units with breakfast, 1 unit with lunch and 2 units with supper. R7's record lacked documentation for insulin set up, to include the dates of insulin setup, name of the insulin, quantity of dose, times to be administered, route of administration and name of person completing medication setup. On January 25, 2023, at 10:05 a.m., LPN-E stated she set up R7's insulin weekly, LPN-E stated she set R7's insulin up yesterday into predrawn syringes, but had not documented the insulin set up. Additionally, LPN-E stated she had not documented R7's weekly medication set up since August 2022. R8 R8's diagnoses included hypertension (high blood pressure).	01770		

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01770	Continued From page 20 R8's service plan dated January 24, 2023, indicated the resident received medication management services. R8's January 2023, EMAR, included: documentation of gabapentin (treats pain) 100 milligram (mg) on hold as of 1/23/2023 3:09 p.m. On January 25, 2023, at 10:00 a.m., The evaluator observed R8's bubble pack of gabapentin 100 mg sitting on LPN-E's desk. LPN-E stated she set up R8's gabapentin from a pharmacy bottle to a bubble pack January 24, 2023. The evaluator observed with LPN-E R8's electronic record and LPN-E stated she had not done the proper documentation at the time of set up, to include the dates of medication setup, name of the medication, quantity of dose, times to be administered, route of administration and name of person completing medication setup. R9 R9's diagnoses included benign prostatic hyperplasia (enlarged prostate gland). R9's service plan dated December 13, 2022, indicated the resident received medication management services. R9's January 2023, EMAR included orders for aspirin (heart health) 81 mg mouth daily, calcium/vit d (supplement) 600mg/20 microgram (mcg) daily, chondroitin/glucosamine/MSM (supplement) 1000mg daily, fish oil 2000 mg (supplement) daily, multivitamin (supplement) daily and tamsulosin (urinary retention) 0.8 mg daily. On January 25, 2023, at 10:03 a.m., LPN-E	01770		

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01770	Continued From page 21 stated R9's medications are set up weekly from bottles to bubble packs. The evaluator observed with LPN-E R9's electronic record and LPN-E stated she had not done the proper documentation at the time of set up, to include the dates of medication setup, name of the medication, quantity of dose, times to be administered, route of administration and name of person completing medication setup. LPN-E stated the last time she had documented medication setup in R9's record was October 2022. The licensee's Medication Management Policy dated July 18, 2022, states documentation of the medications set up will occur in the medical record and must include date of set up, name of medications, quantity of dose, times to be administered, route of administration, name of person completing medications set up, and description of medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01770		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must	01940		

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01940	Continued From page 22 contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop an individual treatment management plan to include all required content for one of three residents (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).	01940		

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01940	Continued From page 23 The findings include: R2's diagnoses included dementia and epilepsy. R2's service plan dated October 1, 2022, indicated R2 received services to include compression stockings (TEDs). R2's physician orders dated September 8, 2022, included TEDs to be applied and removed daily. On January 24, 2023, at approximately 8:00 a.m., the surveyor attempted to observed unlicensed personnel (ULP)-C apply R2's TEDs, however, due to R2's level of anxiety and behaviors with observation, ULP-C verified R2's TEDs had been applied. Additionally, ULP-C stated R2 received assistance every morning with TED application and assistance with TED removal every evening at bedtime. R2's Treatment/Therapy Management Plan lacked the following content: - identification of the treatment or therapy that will be delegated to unlicensed personnel; - procedures for notifying a nurse or appropriate licensed health professional when a problem arises with the treatments or therapy services; and - any resident-specific requirements relating to documenting of treatment and therapy received' verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. On January 25, 2023, at approximately 9:30 a.m., licensed assisted living director (LALD)-A confirmed R2's record lacked a complete and accurate individualized treatment and therapy	01940		

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01940	Continued From page 24 plan. The licensee's Minnesota Assisted Living Treatment and Therapy Management policy dated August 1, 2021, indicated the registered nurse (RN) would update the assessment, care plan, functional assessment and service plan. The licensed staff would communicate to the unlicensed personnel the new service by documenting in the communication book, care plan and daily assignment sheets. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on available record review and interview, the licensee did not provide a hazard vulnerability assessment or safety risk assessment of the physical environment on and around the property	02040		

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02040	Continued From page 25 for the facility. This deficient practice had the ability to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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). Findings include: A record review and interview were conducted January 25, 2023, at approximately 10:30 a.m. with administrator (A)-B, executive director of facilities maintenance (EDM)-G and facilities manager (FM)-I on the hazard vulnerability assessment for the physical environment of the facility. Record review of the available documentation indicated that the licensee had not performed a hazard vulnerability assessment with mitigation factors on and around the interior and exterior of this specific property. This deficiency was verified by A-B, EDM-G and FM-I during the interview at approximately 10:45 a.m. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	02040		

Minnesota Department of Health
Food, Pools & Lodging Section
P.O. Box 64975
Saint Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *01/24/23*
Time: 14:00:00
Report: 6808231028

Food and Beverage Establishment Inspection Report

Location:
Heartwood
500 Heartwood Drive
Crosby, MN56441
Crow Wing County, 18

Establishment Info:
ID #: 0038651
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 2185458500
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.

3-500B Microbial Control: hot and cold holding
3-501.16A2 ***** Priority 1 *****
MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.
FOODS IN THE MEMORY CARE REFRIGERATOR WERE 43 DEGREES. ADJUST AND MONITOR.
Comply By: 01/24/23

2-100 Supervision
2-102.12AMN
MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.
SARAH MARTZ IS NOT STATE CERTIFIED.
Comply By: 03/24/23

3-600 Food Identity
3-602.11A
MN Rule 4626.0435A Label all food packaged in the food establishment as specified in law.
INCLUDE THE WEIGHT/QUANTIY AND THE NAME AND ADDRESS ON THE FOOD LABELS ON PREPACKAGED FOODS AVAILABLE FOR SELF SERVICE. SEE ATTACHED FACT SHEET.
Comply By: 02/24/23

Food and Beverage Establishment Inspection Report

4-200 Equipment Design and Construction

4-204.112A

MN Rule 4626.0620A Provide a temperature measuring device located in the warmest part of mechanically refrigerated units and coolest part of hot food storage units that are capable of measuring air temperature or a simulated product temperature.

PROVIDE A THERMOMETER IN THE MEMORY CARE REFRIGERATOR.

Comply By: 01/24/23

Surface and Equipment Sanitizers

Hot Water: = at 163 Degrees Fahrenheit
Location: DISHWASHERCFINAL RINSE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Line
Temperature: 41 Degrees Fahrenheit - Location: EGGS
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 36 Degrees Fahrenheit - Location: 2-DOOR
Violation Issued: No

Process/Item: Walk-In Cooler
Temperature: 36 Degrees Fahrenheit - Location:
Violation Issued: No

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

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 6808231028 of 01/24/23.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/__/_____

Signed:_____
Establishment Representative

Signed: Lee Ann Austin
Lee Ann Austin
Public Health Sanitarian
St. Cloud
320-223-7341
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