Electronically Delivered

October 21, 2024

Licensee
TR Homes
3301 84th Avenue North
Brooklyn Park, MN 55443

RE: Project Number(s) SL36883015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 21, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

MDH concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

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

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

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

§ 144G.20.

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

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

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

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00

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

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

The correction order documentation should include the following:

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

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

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

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

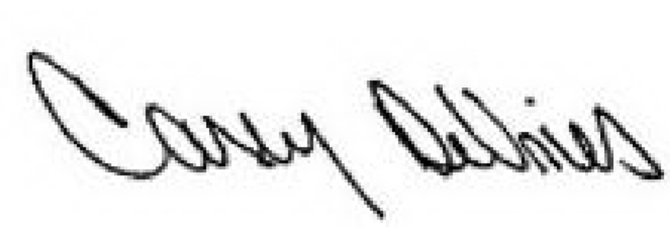
To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms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

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,



Casey DeVries, Supervisor
State Evaluation Team
Email: Casey.DeVries@state.mn.us
Telephone: 651-201-5917 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36883	A. BUILDING: _____ B. WING _____	08/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TR HOMES	3301 84TH AVENUE NORTH BROOKLYN PARK, MN 55443

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(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: SL36883015-0 On August 19, 2024, through August 21, 2024, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were four residents; four receiving services under the Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated August 19, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and	0 510		

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0 510	Continued From page 2 Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an effective infection control program to comply with accepted health care, medical, and nursing standards for infection control related to gloving and hand hygiene for two of two staff, (licensed practical nurse (LPN)-C, and unlicensed personnel (ULP)-D). This had the potential to affect all of the licensee's residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: LPN-C LPN-C was hired November 1, 2022, to provide assisted living services. On August 29, 2024, at 11:49 a.m., LPN-C stated they were responsible for managing and monitoring the medication storage cabinets. On August 19, 2024, at 12:19 p.m., during an audit of the medication storage cabinet, the	0 510		

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0 510	Continued From page 3 surveyor observed an uncapped blood glucose lancet behind some papers and medication boxes. The surveyor informed LPN-C of the finding and advised that the lancet should be properly disposed of to prevent a possible needle stick injury. The surveyor observed LPN-C retrieve the uncapped blood glucose lancet without completing hand hygiene or putting on gloves. LPN-C then disposed of this lancet in the sharp's container. The surveyor did not observe LPN-C perform hand hygiene after disposal of the lancet. On August 19, 2024, at 12:21 p.m., LPN-C stated they were trained to dispose of lancets in the sharps container and were trained to complete hand hygiene before and after donning gloves. ULP-D ULP-D was hired August 24, 2021, to provide assisted living services. On August 20, 2024, at 7:48 a.m., the surveyor observed ULP-D complete hand hygiene at a sink then prepare medications for R4. At 7:57 a.m., the surveyor observed ULP-D enter the room of R4 to obtain vitals and administer medications. At 8:00 a.m., after obtaining vitals and interacting with potentially contaminated surfaces, the surveyor observed ULP-D put on clean gloves without completing hand hygiene to obtain a blood glucose on R4. The surveyor then observed ULP-D exit the room of R4, remove gloves and complete hand hygiene at a sink. On August 20, 2024, 8:08 a.m., ULP-D stated they were trained to complete hand hygiene before and after completing tasks, in between glove changes, and to use hand sanitizer between tasks as needed. ULP-D stated they	0 510		

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0 510	Continued From page 4 usually carried a bottle of hand sanitizer with them but did not have one on them today. The licensee's undated Standard Precautions for All Health Care Workers policy indicated gloves, such as vinyl or latex medical gloves, must be worn when cleaning reusable equipment; when having direct contact with blood, body fluids, mucous membranes or non-intact skin; when handling items soiled with blood; or when handling equipment contaminated with blood or body fluids. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a 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	0 660		

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0 660	Continued From page 5 by: Based on interview and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), which included a two-step tuberculin skin test (TST) or other evidence of TB screening such as a blood test for one of two employees (licensed practical nurse (LPN)-C). 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 TB risk assessment dated March 29, 2024, indicated the facility was a low risk. LPN-C was hired November 1, 2022, to provide assisted living services. LPN-C's employee record contained TB symptoms screening dated November 1, 2021, and the results of a chest x-ray with a negative reading dated August 7, 2015. The documentation indicated that the x-ray was completed due to nonspecific reaction to tuberculin skin test without active tuberculosis. LPN-C's record lacked documentation of a positive tuberculin skin test to correlate with the chest x-ray.	0 660		

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0 660	Continued From page 6 On August 21, 2024, at 1:49 p.m., licensed assisted living director/ clinical nurse supervisor (LALD/CNS)-B stated that LPN-C had worked with a contract agency prior to being hired directly with the licensee. LALD/CNS-B stated this documentation was obtained when LPN-C was hired under the licensee. LALD/CNS-B stated there was no further documentation available for review, and that going forward, the licensee would ensure staff had the required TB documentation. The licensee's undated Tuberculosis Prevention and Control policy indicated the facility will establish a protocol for early identification of individuals with active tuberculosis. The facility will, at no cost to the employee, offer TB Mantoux skin test or a blood test at the time of employment, and as indicated in situations of TB exposure. Employees who can show evidence of a negative Mantoux within three (3) months prior to hire date may use that test as step one of two step test at the time of employment. Employees who have documentation of a negative blood test or a negative Chest X-ray within three (3) months of employment do not need to have it repeated. The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and based on CDC guidelines, indicated an employee may begin working with patients after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW (health care worker) starts working with patients. Baseline TB screening should be documented in the employee's record."	0 660		

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0 660	Continued From page 7 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing 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 maintain a written	0 680		

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0 680	Continued From page 8 emergency preparedness (EP) plan with all the required content as defined in Appendix Z and failed to post an emergency preparedness plan prominently. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On August 19, 2024, at 1:37 p.m., the surveyor requested the licensee's emergency preparedness plan (EPP) for review. The surveyor observed agent (A)-A taking the emergency preparedness plan out of a binder titled Mock Survey. The licensee failed to post an emergency disaster plan prominently. The licensee's written emergency disaster preparedness plan lacked evidence of the following required content: - Annual review of the Emergency Preparedness Plan; - Quarterly review of missing resident policy; - A written risk assessment utilizing an all-hazards approach; - Categorization of probable risks by likelihood of occurrence; - Written strategies addressing facility and community-based risks; - Missing Resident Plan; - Policies and procedures to identify at risk	0 680		

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0 680	Continued From page 9 population needs like maintaining independence, communication, transportation, supervision, and medical care; - Development of Communication Plan; and - Sharing information on occupancy needs. On August 21, 2024, at 1:45 p.m., licensed assisted living director/ clinical nurse supervisor (LALD/CNS)-B stated they were under the assumption the EPP was complete in its content and was not aware of any deficits. The licensee's undated Emergency Management Policy indicated that the facility would have an identified plan in place to ensure the safety and well-being of residents and employees during periods of an emergency or disaster that disrupts facility services. The licensee's undated Hazard Vulnerability Analysis indicated the proactive risk assessment or Hazard Vulnerability Analysis (HVA) will be performed using an all-hazards approach to identify possible emergency events the facility could experience that could interfere with the delivery of care and services. Additionally, the HVA will be conducted initially when developing the Emergency Preparedness Plan, upon identification of any new external risk factor, when beginning a new service, and annually. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 700 SS=F	144G.43 Subdivision 1 Resident record (b) Resident records, whether written or	0 700		

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0 700	Continued From page 10 electronic, must be protected against loss, tampering, or unauthorized disclosure in compliance with chapter 13 and other applicable relevant federal and state laws. The facility shall establish and implement written procedures to control use, storage, and security of resident records and establish criteria for release of resident information. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure resident's personal health and medical information was kept private for four of four residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On August 19, 2024, at 11:33 a.m., during a tour of the facility, the surveyor observed a calendar posted at the top of a staircase in the licensee's main living area. The calendar contained resident names and information related to their upcoming medical appointments. On August 21, 2024, at 1:47 a.m., licensed assisted living director/ clinical nurse supervisor (LALD/CNS)-B stated private health information should not be posted in a public area and at a minimum, abbreviations should be utilized instead of resident names.	0 700		

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TR HOMES	3301 84TH AVENUE NORTH BROOKLYN PARK, MN 55443

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 700	Continued From page 11 The licensee's undated Resident Record policy indicated that all resident information shall be regarded as confidential and available to only authorized users. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 700		
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;	0 780		

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0 780	Continued From page 12 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that functioned and were interconnected so that the actuation of one alarm caused all alarms in the dwelling unit to actuate. This deficient condition had the ability to affect 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 August 20, 2024, from approximately 10:22 a.m. to 11:20 a.m., survey staff toured the facility with house manager (HM)-E. Survey staff tested the smoke alarms throughout the home. Upon testing, the smoke alarms in the following locations did not sound when the test button was pressed: 1. The smoke alarms were not interconnected throughout the facility. These deficient conditions were visually verified by HM-E accompanying on the tour and he stated that he understood the smoke alarm requirements. No further information was provided.	0 780		

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0 780	Continued From page 13 TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the portable fire extinguishers. This deficient condition 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On August 20, 2024, from approximately 10:22	0 790		

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0 790	Continued From page 14 a.m. to 11:20 a.m., survey staff toured the facility with housing manager (HM)-E and observed that the fire extinguishers throughout the facility, did not have current tags or documentation to indicate that monthly and annual inspections had been performed as required. Annual inspections of the fire extinguishers are required to ensure that all systems are maintained and remain in working order. HM-E verbally confirmed survey staff observations. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		
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 with regard to the health, safety, comfort, and well-being of the residents. This deficient condition had the	0 800		

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0 800	Continued From page 15 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 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 August 20, 2024, from approximately 10:22 a.m. to 11:20 a.m., survey staff toured the facility with house manager (HM)-E. The following was observed. GENERAL MAINTENANCE: Scratches on the bathroom door on the main floor. Bedroom # 2 had some holes patched but was missing paint. Also, a stain was found on the carpet by the door. Bedroom # 1 had holes in the door. Bedroom # 5 had a space heater plugged into an extension cord. Cement was cracked on the sidewalk by the front door entrance. Deck finish was coming off and wood was deteriorating. HM-E stated they understood the above-listed	0 800		

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0 800	Continued From page 16 deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (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	0 810		

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0 810	Continued From page 17 drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required training and drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On August 20, 2024, at approximately 11:15 a.m., house manager (HM)-E provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN: The FSEP (fire safety and evacuation plan) 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 plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate) and was very basic. The provided FSEP had not been updated to meet the specific	0 810		

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0 810	Continued From page 18 layout of this facility and provide complete actions for employees to take in the event of a fire or similar emergency. Emergency evacuation map did not show the emergency exits. Drills: The licensee failed to provide evacuation drills to staff as required. HM-E stated that drills were being done quarterly and had the documentation to back it up. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 950 SS=C	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable."	0 950		

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0 950	Continued From page 19 (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to offer the resident the opportunity to identify a designated representative in writing with the required statutory language. 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: R1 admitted to licensee on March 1, 2023, and began receiving assisted living services. R1's Resident Contract for Assisted Living was signed on March 1, 2023. R1's record lacked documentation of the opportunity to designate a representative and the verbatim "right to designate a representative for certain purposes" notice.	0 950		

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0 950	Continued From page 20 On August 20, 2024, at 2:03 p.m., licensed assisted living director/ clinical nurse supervisor (LALD/CNS)-B confirmed the contract utilized for R1 was the same contract utilized for all residents within the facility. LALD-B stated they were unaware of there being a designated representative form, but agent (A)-A may know. On August 21, 2024, at 10:28 a.m., unlicensed personnel (ULP)-D stated they were instructed to relay a message from A-A stating the facility did not have a designated representative form in use for residents to utilize. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 950		
01290 SS=D	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of 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.	01290		

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01290	Continued From page 21 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a background study (BGS) was submitted and a clearance received in affiliation with the assisted living licensee's current health facility identification (HFID) for one of two employees (licensed practical nurse (LPN-C)). 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: LPN-C was hired November 1, 2022, to provide assisted living services. On August 19, 2024, the surveyor observed LPN-C performing chart reviews in the kitchen area of the assisted living facility. LPN-C's employee record contained a background check clearance letter dated August 19, 2024, completed during the survey. LPN-C's record lacked any previous background checks for the licensee's HFID 36883. The licensee was able to provide a previously run background check for LPN-C from an affiliated facility HFID 36875. On August 20, 2024, 11:15 a.m., agent (A)-A stated LPN-C had been dropped from the	01290		

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01290	Continued From page 22 licensee's NETStudy 2.0 (web-based system used to submit background study requests to the Department of Human Services) roster for some reason. A-A was unable to give a date or reason for LPN-C being dropped from the roster. On Augst 21, 2024, at 1:50 p.m., licensed assisted living director/ clinical nurse supervisor (LALD/CNS)-B stated the expectation for the licensee was for staff to have a cleared background check prior to providing services to residents. The licensee's undated Background Studies policy indicated that employees may not work until the results of the background study have been received. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01470 SS=D	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff	01470		

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01470	Continued From page 23 responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication	01470		

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01470	Continued From page 24 access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employees completed required orientation before providing services for one of two direct care employees, licensed practical nurse (LPN)-C. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: LPN-C was hired November 1, 2022, to provide assisted living services. LPN-C's record contained an orientation check list as well as an Educare (online training program) transcript. LPN-C's record lacked documentation of the following required orientation content: - Overview of Assisted Living statutes; and - Consumer advocacy services. On August 20, 2024, at 11:52 a.m., The surveyor asked agent (A)-A to assist in finding the missing required components for training. A-A stated the components were not found in LPN-C's training record, and they would make sure that LPN-C was assigned the required training topics. No further information was provided.	01470		

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01470	Continued From page 25 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
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) conducted ongoing resident monitoring and reassessments, not to exceed 90 calendar days from the last date of assessment and failed to	01620		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TR HOMES	3301 84TH AVENUE NORTH BROOKLYN PARK, MN 55443

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01620	Continued From page 26 ensure the RN completed ongoing resident reassessments to include all areas required on the uniform assessment tool 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 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 was admitted to the licensee on March 1, 2023, to receive assisted living services. R1's diagnoses include type 2 diabetes, vitamin D deficiency, generalized anxiety disorder, primary insomnia, peripheral vascular disease, chronic obstructive pulmonary disease with acute lower respiratory infection, gastroesophageal reflux, low back pain, and shortness of breath. R1's service plan, dated March 1, 2023, indicated R1 received comprehensive assessments, reassessment after start of care, and every 90 days. Additionally, R1 received assistance with bathing, grooming, dressing, shopping, housekeeping, meal preparation, behavior management, medication administration, medication management transportation, laundry, incontinence care, and oxygen management. R1's record contained an admission assessment dated March 1, 2023, and a 14-day reassessment dated March 15, 2023. R1's record contained an	01620		

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01620	Continued From page 27 assessment document titled Uniform Assessment Tool. The most recent date the uniform assessment tool was utilized was November 27, 2023. Assessments dated March 1, 2024, May 1, 2024, and August 2, 2024, were all completed utilizing a form titled 90 Day Home Care Reassessment - Non-Skilled care and lacked the following areas on the uniform assessment tool: - the resident's personal lifestyle preferences; - activities of daily living; - instrumental activities of daily living; - emotional and mental health conditions; - list of treatment; - risk indicators; - who has decision making authority for the resident; and - the need for follow-up referral. On August 20, 2024, at 2:01 p.m., licensed assisted living director/ clinical nurse supervisor (LALD/CNS)-B stated they had adopted the process of using the 90 Day Home Care Reassessment - Non-Skilled care form as the 90-day assessment form as a means of taking notes during 90-day assessments and then would update the uniform assessment tool. LALD/CNS-B stated this process was developed to save time. LALD/CNS-B stated they may have forgotten to update the document titled Uniform Assessment Tool, or to reference this tool in the assessment completed utilizing the 90 Day Home Care Reassessment - Non-Skilled care form. LALD/CNS-B stated the same would apply to all resident records. On August 21, 2024, at 2:08 p.m., LALD/CNS-B stated going forward, the licensee would complete a new assessment utilizing the Uniform Assessment Tool for all 90-day assessments. Additionally, they would go through and audit all	01620		

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01620	Continued From page 28 resident records to ensure compliance. The licensee's Nursing Assessment and Reassessment of Residents policy indicated a comprehensive assessment is conducted by a registered nurse pre-admission, completed within 14 days after start of services, with change in condition and at least every 90 days. The assessment includes but is not limited to the requirements outlined in MN Rules. Current assessment and past medical history are reviewed if the documentation is available to the nurse. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01710 SS=F	144G.71 Subd. 3 Individualized medication monitoring and reas The assisted living facility must monitor and reassess the resident's medication management services as needed under subdivision 2 when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse completed face-to-face medication management re-assessments at least annually for two of two residents (R1, R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or	01710		

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01710	Continued From page 29 safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 R1 was admitted to the licensee on March 1, 2023, to receive assisted living services. R1's diagnoses include type 2 diabetes, vitamin D deficiency, generalized anxiety disorder, primary insomnia, peripheral vascular disease, chronic obstructive pulmonary disease with acute lower respiratory infection, gastroesophageal reflux, low back pain, and shortness of breath. R1's service plan, dated March 1, 2023, indicated that R1 received assistance with medication management. R1's record included a medication management assessment dated March 15, 2023. However, R1's medical record lacked documentation indicating an annual medication management assessment was completed thereafter. R4 R4 was admitted to the licensee on May 24, 2022, to receive assisted living services. R4's diagnoses included type 2 diabetes mellitus, adjustment disorder with anxiety and depressed mood, Bell's palsy, polyneuropathy, paralytic lagophthalmos left eye, legal blindness, peripheral vertigo, essential hypertension, cerebral infarction due to thrombosis of other	01710		

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01710	Continued From page 30 cerebral artery, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, and constipation. R4's service plan, dated May 24, 2022, indicated that R4 received assistance with medication management. R4's record included a medication management assessment dated May 24, 2022. However, R4's medical record lacked documentation indicating an annual medication management assessment was completed thereafter. R4's medication assessment and management plan dated May 24, 2022, indicated R4 was unable to complete the following tasks in self-administration of medications: - Can correctly state what each medication is for; - Can correctly state the proper dosage; - Can demonstrate ability to open mediation containers; - Can correctly measure the appropriate amount of medication from container; - Can correctly document self-administration of the medications; - Can demonstrate secure storage of medications kept in room; and - Can correctly document the administration of PRN medications. On August 20, 2024, at 8:08 a.m., the surveyor observed two bottles of over the counter Tylenol in the room of R4. On August 20, 2024, at 2:07 p.m., licensed assisted living director/ clinical nurse supervisor (LALD/CNS)-B stated they believed there was a more up to date medication management plan on file for R1 and R4. Additionally, LALD/CNS-B	01710		

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01710	Continued From page 31 stated they were unaware the R4 had the medications in their room, and suspected that they may have been brought in by R4's family. LALD/CNS-B stated they would ensure that the medications were securely stored. On August 21, 2024, at 2:08 p.m., LALD/CNS-B stated they were unable to locate any additional medication management assessments for R1 or R4. The licensee's undated Individualized Medication Managment Plan and Record policy indicated the registered nurse (RN) will ensure that eash resident's Individualized Medication Management Plan is kept up-to-date adn consistent with prescribers orders and with the needs and preferences of the residnet. Additionally, the RN will monitor and reassess the resident's medication management services at least every 90 days or more frequently based on the RN's judgment. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01710		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	01880		

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01880	Continued From page 32 review, the licensee failed to store all prescription medications securely to permit only authorized personnel to have access. 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 August 19, 2024, at 11:49 a.m., during an audit of the licensee's medication storage, the surveyor observed a box containing a vial of Haloperidol Decanoate 100mg/ml which had its medication label removed, on top of the licensee's medication storage cabinet. The licensee's medication storage cabinet was located between the licensee's main living area and kitchen, which would allow easy access residents, visitors, or other unauthorized persons. The surveyor also observed a box belonging to R1 which contained an Albuterol Sulfate HFA Inhalation Aerosol 90mcg per actuation inhaler on top of the medication storage cabinet. On August 21, 2024, licensed assisted living director/ clinical nurse supervisor (LALD/CNS)-B stated medications should be stored securely in the medication cart and going forward staff would be expected to complete regular audits of the facilities medication storage. The licensee's undated Medication Set Up policy indicated all medication should be stored in the	01880		

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01880	Continued From page 33 facility in a safe and secure location which is out of sight from visitors to the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug as well as disposing of expired medications. This had a potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents).	01890		

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01890	Continued From page 34 The findings include: On August 19, 2024, at 11:49 a.m., during an audit of the licensee's medication storage, the surveyor observed the following expired medications: - Three cards of acetaminophen 500mg tablets belonging to R4, with an expiration date of July 16, 2024. - One bottle of ibuprofen 200mg tablets with an expiration date of June 2024. - One bottle of Aripiprazole 10mg tablets belonging to R3, with an expiration of August 5, 2023. - One vial of Haloperidol Decanoate 100mg/ml belonging to R3, with an expiration date of August 17, 2023. On August 19, 2024, at 12:09 p.m., during an audit of the licensee's medication storage, the surveyor observed an orange prescription bottle containing a large number of pills. The bottle had the original label removed, and a label made of paper tape with the name of R3 on one side and Benztropine 1mg on the other. On August 19, 2024, at 12:09 p.m., licensed practical nurse (LPN)-C stated that the pills in the orange bottle were collected over time as R3 would refuse the medication at every med pass. LPN-C stated they were in the process of having these medications discontinued by R3's doctor. The surveyor questioned LPN-C why the medications were collected in this manner, instead of just being disposed of. LPN-C was unable to give a reason as to why the medications were not immediately disposed of but stated it would be best practice to dispose of the medications immediately after refusal by R3.	01890		

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01890	Continued From page 35 During this interaction, agent (A)-A stated that medications are to be labeled, removed, and secured for destruction at a later time. The licensee's undated Medication Disposition or Disposal policy indicated unused drugs are to be destroyed and documentation of the destruction, indicating the date, quantity, name of drug, prescription number, signature of person destroying the drugs, and signature witness to the destruction must be recorded in the record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
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 provide care and services according to acceptable health care standards, medical, or nursing standards for one of one resident (R1) who utilized oxygen. 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	02310		

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02310	Continued From page 36 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 August 21, 2024, during an interview with R1, the surveyor observed an at home refillable oxygen tank system, an oxygen concentrator, a large oxygen container sitting in a floor base system, and one unsecured portable oxygen tank. The surveyor inquired if the licensee had provided a device to secure the unsecured oxygen tank. R1 stated that they did not have a rack to secure their oxygen tank, and they would want to have one. On August 21, 2024, at 2:01 p.m., in a joint phone interview, licensed assisted living director/ clinical nurse supervisor (LALD/CNS)-B and agent (A)-A stated that were not aware that portable oxygen tanks should be stored in racks. The licensee's undated Safe Oxygen Use and Storage policy indicated that the facility staff will ensure that the resident has an appropriate storage cart or stand for the oxygen cylinder or oxygen concentrator and will educate the resident/resident's representative about safe use and storage of oxygen. Minnesota Department of Health (MDH) Oxygen Cylinder Storage Requirements dated April 16, 2020, recommended cylinders be secured with chains or racks to prevent cylinders from falling over. No further information was provided.	02310		

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02310	Continued From page 37 TIME PERIOD FOR CORRECTION: Seven (7) days	02310		
02320 SS=F	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure unlicensed personnel (ULP-D) followed appropriate medication administration procedures for all residents currently residing within 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 of the residents). The findings include: ULP-D was hired on August 24, 2021, to provide assisted living services to residents. ULP-D's employee record included medication training completed on August 31, 2021, and medication competency completed on September	02320		

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02320	Continued From page 38 30, 2021. R4 R4 was admitted to the licensee on May 24, 2022, to receive assisted living services. R4's service plan, dated May 24, 2022, indicated R4 received assistance with medication management. R4's medication assessment and management plan dated May 24, 2022, indicated R4 was unable to complete the following tasks in self-administration of medications: - Can correctly state what each medication is for; - Can correctly state the proper dosage; - Can demonstrate ability to open mediation containers; - Can correctly measure the appropriate amount of medication from container; - Can correctly document self-administration of the medications; - Can demonstrate secure storage of medications kept in room; and - Can correctly document the administration of PRN medications. On August 20, 2024, 7:52 a.m., the surveyor observed ULP-D prepare medications for R4. The surveyor observed ULP-D put the following medications into a medication cup for administration to R4: - Aspirin 81mg tablet; - Amlodipine 5mg tablet; - Clopidogrel 75mg tablet; - Glipizide 5mg tablet; - Jardiance 25 mg tablet; and - Lisinopril 40mg tablet. On August 20, 2024, at 8:08 a.m., the surveyor	02320		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02320	Continued From page 39 observed ULP-D leave the medication cup containing the morning medications for R4 on the table in R4's room. ULP-D then provided a reminder to R4 to take their morning medications. ULP-D did not stay in room to observe R4 take their provided medications. On August 21, 2024, at 10:54 a.m., ULP-D stated they were not trained to leave medications unattended in resident rooms, and stated this was an error on their behalf. R1 R1 was admitted to the licensee on March 1, 2023, to receive assisted living services. R1's service plan, dated March 1, 2023, indicated that R1 received assistance with medication management. R1's medication assessment and management plan dated December 15, 2023, indicated that R1 was unable to complete the following tasks in self-administration of medications: - Can correctly state what medications are to be taken; - Can correctly state what each medication is for; - Can correctly state what time medications are to be taken; - Can correctly state the proper dosage; - Can demonstrate ability to open mediation containers; and - Can demonstrate secure storage of medications kept in room. On August 21, 2024, at 12:56 p.m., during an interview with R1, the surveyor observed a pill organizer sitting on R1's bedside table. The pill organizer was separated into four segments labeled "MORN, NOON, EVE, and BED". The	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36883	A. BUILDING: _____ B. WING _____	08/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TR HOMES	3301 84TH AVENUE NORTH BROOKLYN PARK, MN 55443

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02320	Continued From page 40 compartments labeled "MORN" and "NOON" were empty. There were unidentified medications observed in the compartments labeled "EVE" and "BED". R1 stated that ULP-D left these medications in their room. On August 21, 2024, at 1:03 p.m., ULP-D stated R1 will take their medications independently with reminders. ULP-D stated they were not trained to complete medication administration in this manner but just did it that way sometimes. On August 21, 2024, at 2:05 p.m., licensed assisted living director clinical nurse supervisor (LALD/CNS)-B stated medications should not be left in resident rooms, staff were not trained to leave medications in resident rooms, and they would ensure staff was retrained on medication administration. The licensee's undated Medication Management Services policy indicated the registered nurse (RN) will develop and implement medication training curriculum and competency evaluations to assure that licensed and unlicensed staff is trained and competent to perform all delegated medication management tasks. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		

Minnesota Department of Health

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

Type: Full
Date: *08/19/24*
Time: 13:00:00
Report: 8087241195

Food and Beverage Establishment Inspection Report

Location:

Tr Homes
3301 84th Avenue North
Brooklyn Park, MN55443
Anoka County, 02

Establishment Info:

ID #: 0038893
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7637627144
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.

No NEW orders were issued during this inspection.

Food and Equipment Temperatures

Process/Item: Ambient Air
Temperature: -12 Degrees Fahrenheit - Location: KITCHEN - STAND UP FREEZER
Violation Issued: No

Process/Item: Ambient Air
Temperature: 39 Degrees Fahrenheit - Location: KITCHEN - STAND UP REFRIGERATOR
Violation Issued: No

Process/Item: Cold Holding: CHEESE
Temperature: 39 Degrees Fahrenheit - Location: KITCHEN - STAND UP REFRIGERATOR
Violation Issued: No

Process/Item: Cold Holding: SOUR CREAM
Temperature: 39 Degrees Fahrenheit - Location: KITCHEN - STAND UP REFRIGERATOR
Violation Issued: No

Process/Item: Ambient Air
Temperature: 11 Degrees Fahrenheit - Location: GARAGE - STAND UP FREEZER
Violation Issued: No

Process/Item: Ambient Air
Temperature: -4 Degrees Fahrenheit - Location: GARAGE - CHEST FREEZER
Violation Issued: No

Process/Item: Ambient Air
Temperature: 32 Degrees Fahrenheit - Location: GARAGE - STAND UP REFRIGERATOR
Violation Issued: No

Process/Item: Cold Holding: MILK
Temperature: 32 Degrees Fahrenheit - Location: GARAGE - STAND UP REFRIGERATOR
Violation Issued: No

Type: Full
Date: *08/19/24*
Time: 13:00:00
Report: 8087241195
Tr Homes

Food and Beverage Establishment Inspection Report

Process/Item: Cold Holding: DELI MEAT
Temperature: 32 Degrees Fahrenheit - Location: GARAGE - STAND UP REFRIGERATOR
Violation Issued: No

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

THIS WAS AN ANNOUNCED AND SCHEDULED FULL INSPECTION.

INSPECTION CONDUCTED IN THE PRESENCE OF NURSE EVALUATOR ZACHARY MORTH.

FLOORS AND CABINETS ARE HARDWOOD. CEILING IS TEXTURED AND DOES NOT APPEARS TO BE DURABLE, SMOOTH IN TEXTURE OR EASILY CLEANABLE. ALL ARE FOUND TO BE IN GOOD CONDITION AND WILL BE MONITORED AT FUTURE INSPECTIONS. IF AT SUCH A TIME THEY ARE FOUND TO BE A CONCERN OR RISK OF CONTAMINATION, THEY WILL BE ORDERED TO BE REPLACED AND BROUGHT UP TO CODE.

HOT WATER TEMPERATURE AT THE KITCHEN SINK REACHED 120 DEGREES.

DESIGNATED HAND WASHING SINK IN THE KITCHEN (RIGHT SIDE OF A 2-BIN, STAINLESS STEEL RESIDENTIAL KITCHEN SINK).

INSPECTION REPORT EMAILED TO ZACHARY MORTH AND MANAGER BAYI DARWALLS.

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 8087241195 of 08/19/24.

Certified Food Protection Manager: JAMEELAH T. NANCE

Certification Number: FM119532 Expires: 09/21/26

Inspection report reviewed with person in charge and emailed.

Signed: _____
BAYI DARWALLS
MANAGER

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