DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

January 4, 2023

Licensee
3Care Health LLC
6273 West 144th Street
Savage, MN 55378

RE: Project Number(s) SL36299015

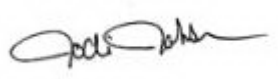
Dear Licensee:

On December 23, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine if orders from the August 17, 2022, evaluation were corrected. This follow-up evaluation verified that the facility is in substantial compliance.

It is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body. You are encouraged to retain this document for your records.

Please feel free to call me with any questions.

Sincerely,



Jodi Johnson, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: jodi.johnson@state.mn.us
Telephone: 507-344-2730 Fax: 651-215-9697

HHH

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

November 14, 2022

Administrator
3care Health, LLC
6273 West 144th Street
Savage, MN 55378

RE: Project Number(s) SL36299015

Dear Administrator:

On October 25, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine correction of orders found on the evaluation completed on August 17, 2022. This follow-up evaluation determined your facility had not corrected all of the state licensing orders issued pursuant to the August 7, 2022 evaluation.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state licensing orders issued pursuant to the last evaluation completed on August 17, 2022, found not corrected at the time of the October 25, 2022, follow-up evaluation and/or subject to penalty assessment are as follows:

0810-Fire Protection And Physical Environment-144g.45 Subd. 2 (b)-(f) = $500

The details of the violations noted at the time of this follow-up evaluation completed on October 25, 2022 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $500**. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), by the correction order date, the licensee must document in the provider's records any action taken to comply with the correction order by the correction order date. The commissioner may request a copy of this documentation and the assisted living facility's action to respond to the correction orders in future evaluations, upon a complaint investigation, and as otherwise needed.

IMPOSITION OF FINES:

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

authorized in §144G.20.

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

CORRECTION ORDER RECONSIDERATION PROCESS

In accordance with Minn. Stat. § 144G.32, Subd. 2, you have one opportunity to challenge the correction order issued, including the level and scope, and any fine assessed through the correction order reconsideration process. This written request must be received by the Department of Health within 15 calendar days of the correction order receipt date. Please send your written request via email to the following:

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970
Health.HRD.Appeals@state.mn.us

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. Requests for hearing may be emailed to **Health.HRD.Appeals@state.mn.us**.

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.

We urge you to review these orders carefully. If you have questions, please contact Jodi Johnson at 507-344-2730.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Sincerely,

Jodi Johnson, Supervisor
State Evaluation Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 507-344-2730 Fax: 651-215-9697

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36299	A. BUILDING: _____ B. WING _____	R 10/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
3CARE HEALTH LLC	6273 WEST 144TH STREET SAVAGE, MN 55378

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{0 000}	Initial Comments Initial comments *****ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: Project SL36299015 On October 24, 2022, through October 25, 2022, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on August 17, 2022. At the time of the survey, there were two residents receiving services under the Assisted Living license. As a result of the revisit, the following orders were reissued.	{0 000}	Minnesota Department of Health is documenting the State 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.	
{0 460} SS=F	144G.41 Subdivision 1 Minimum requirements (5) provide a means for residents to request	{0 460}		

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{0 460}	Continued From page 1 assistance for health and safety needs 24 hours per day, seven days per week; (6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract; (7) permit residents access to food at any time; (8) allow residents to choose the resident's visitors and times of visits; (9) allow the resident the right to choose a roommate if sharing a unit; (10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living facility must not lock a resident in the resident's unit; This MN Requirement is not met as evidenced by: No further action required.	{0 460}		
{0 470} SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster	{0 470}		

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{0 470}	Continued From page 2 situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: No further action required.	{0 470}		
{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	{0 480}		

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{0 480}	Continued From page 3 This MN Requirement is not met as evidenced by: No further action required.	{0 480}		
{0 550} SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities, and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: No further action required.	{0 550}		
{0 570} SS=C	144G.42 Subdivision 1 Display of license The original current license must be displayed at the main entrance of each assisted living facility. The facility must provide a copy of the license to any person who requests it. This MN Requirement is not met as evidenced by: No further action required.	{0 570}		
{0 580} SS=F	144G.42 Subd. 2 Quality management	{0 580}		

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{0 580}	Continued From page 4 The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: No further action required.	{0 580}		
{0 640} SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by:	{0 640}		

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{0 640}	Continued From page 5 No further action required.	{0 640}		
{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 by: No further action required.	{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;	{0 680}		

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{0 680}	Continued From page 6 (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually 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: No further action required.	{0 680}		
{0 810} SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) 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	{0 810}		

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{0 810}	Continued From page 7 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 maintain the fire safety and evacuation plan and failed to develop a fire safety and evacuation plan with required elements. 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 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 desk record review was conducted on October 24, 2022, at approximately 11:30 a.m. of	{0 810}		

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{0 810}	Continued From page 8 documents provided by Licensed Assisted Living Director/ Registered Nurse (LALD/ RN)-E on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. Record review of the available documentation indicated that the licensee did not maintain the fire safety and evacuation plan for the facility. Review of the document provided titled "9.06 Fire Policy" dated 9/10/22 contained the following discrepancies: - The policy states that residents should be evacuated to the safest exit or nearest set of smoke compartment doors away from fire and smoke. This facility is a residential home and does contain any sort of smoke compartments or smoke compartment doors to contain fire and smoke. - The policy also stated that if the smoke alarm is sounding, the fire departments will be on the way automatically. The facility is a residential home and does not contain a monitored central fire alarm system that will automatically notify responders to come in the event of an emergency. - The policy states that sprinklers will activate in the facility if necessary. The facility also does not contain automatic fire sprinklers as indicated. - The policy states that when the fire alarm is triggered all fire doors on magnetic holders will automatically close to contain smoke and fire and that residents are to remain behind these doors. The facility does not have any doors that are on magnetic door holders or that are rated for smoke and fire. The facility also does not have a fire	{0 810}		

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{0 810}	Continued From page 9 alarm system that supports the use of magnetic door holders. - The policy states that the fire department will dispatch immediately automatically due the system being wired directly to the fire station. The facility has single station smoke alarms that only alarm locally in the building and does not have a central fire alarm system that is monitored that would notify fire department of any emergencies. - The policy states that the fire department will need to come and shut off any alarms that if the alarm does shut of the employee can open the fire doors and continue operations with residents in the building. The facility has single station smoke alarms only and the fire department does not come out to operate or deactivate localized residential alarms. The facility also does not contain fire doors as indicated. Record review of the available documentation indicated that the licensee did not have fire protection procedures necessary for residents included in the fire safety and evacuation plan. Record review of the available documentation indicated that the fire safety and evacuation plan did not include 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. All deficiencies were relayed to LALD/ RN-E via email. LALD/ RN-E verified receipt of the email an provided additional policies, none of which had any bearing on the fire safety and evacuation plan deficiencies.	{0 810}		

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{0 810}	Continued From page 10 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	{0 810}		
{0 920} SS=C	144G.50 Subd. 2 (c) Contract information (c) The contract must include: (1) a disclosure of the category of assisted living facility license held by the facility and, if the facility is not an assisted living facility with dementia care, a disclosure that it does not hold an assisted living facility with dementia care license; (2) a description of all the terms and conditions of the contract, including a description of and any limitations to the housing or assisted living services to be provided for the contracted amount; (3) a delineation of the cost and nature of any other services to be provided for an additional fee; (4) a delineation and description of any additional fees the resident may be required to pay if the resident's condition changes during the term of the contract; (5) a delineation of the grounds under which the resident may be discharged, evicted, or transferred or have services terminated; (6) billing and payment procedures and requirements; and (7) disclosure of the facility's ability to provide specialized diets. This MN Requirement is not met as evidenced by: No further action required.	{0 920}		
{0 930} SS=C	144G.50 Subd. 2 (d-e; 1-4) Contract information (d) The contract must include a description of the facility's complaint resolution process available to	{0 930}		

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{0 930}	Continued From page 11 residents, including the name and contact information of the person representing the facility who is designated to handle and resolve complaints. (e) The contract must include a clear and conspicuous notice of: (1) the right under section 144G.54 to appeal the termination of an assisted living contract; (2) the facility's policy regarding transfer of residents within the facility, under what circumstances a transfer may occur, and the circumstances under which resident consent is required for a transfer; (3) contact information for the Office of Ombudsman for Long-Term Care, the Ombudsman for Mental Health and Developmental Disabilities, and the Office of Health Facility Complaints; (4) the resident's right to obtain services from an unaffiliated service provider; This MN Requirement is not met as evidenced by: No further action required.	{0 930}		
{0 950} SS=D	144.50 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	{0 950}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36299	A. BUILDING: _____ B. WING _____	R 10/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
3CARE HEALTH LLC	6273 WEST 144TH STREET SAVAGE, MN 55378

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{0 950}	Continued From page 12 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." (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: No further action required.	{0 950}		
{01470} SS=F	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);	{01470}		

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{01470}	Continued From page 13 (5) the assisted living bill of rights and staff 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	{01470}		

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{01470}	Continued From page 14 and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: No further action required.	{01470}		
{01650} SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters.	{01650}		

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{01650}	Continued From page 15 This MN Requirement is not met as evidenced by: No further action required.	{01650}		
{01730} SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use	{01730}		

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{01730}	Continued From page 16 to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: No further action required.	{01730}		
{01790} SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and	{01790}		

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{01790}	Continued From page 17 (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: No further action required.	{01790}		

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{01910} SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: No further action required.	{01910}		

Electronically Delivered

September 9, 2022

Administrator
3care Health LLC
6273 West 144th Street
Savage, MN 55378

RE: Project Number(s) SL36299015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on August 17, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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 . . ."

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 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.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation

that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The Department of Health 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 (a)(5)(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 evaluation:

St - 0 - 0115 - 144g.10 Subd. 2 - Licensure Categories - $3,000.00

The total amount you are assessed is $3,000.00. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

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

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

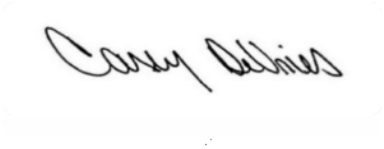
REQUESTING A HEARING

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. Requests for hearing may be emailed to **Health.HRD.Appeals@state.mn.us**.

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.

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
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St. Paul, MN 55101-3879
Email: casey.devries@state.mn.us
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HHH

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0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL36299015-0 On August 15, 2022, through August 17, 2022, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were three residents, all of whom received services under the provider's Assisted Living 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.	
0 115 SS=G	144G.10 Subd. 2 Licensure categories (a) The categories in this subdivision are	0 115		

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0 115	Continued From page 1 established for assisted living facility licensure. (1) The assisted living facility category is for assisted living facilities that only provide assisted living services. (2) The assisted living facility with dementia care category is for assisted living facilities that provide assisted living services and dementia care services. An assisted living facility with dementia care may also provide dementia care services in a secured dementia care unit. (b) An assisted living facility that has a secured dementia care unit must be licensed as an assisted living facility with dementia care. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure it admitted and provided assisted living services within the scope of licensure for one of three residents (R2) with records reviewed. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: The facility was licensed as an assisted living facility (ALF) under Minnesota statutes 144G. During the entrance conference on August 16, 2022, at approximately 9:15 a.m., licensed assisted living director/registered nurse (LALD/RN)-E confirmed they were licensed as an ALF.	0 115	On August 16, 2022, the immediacy of correction order 0115 was removed, however non-compliance remained at a level three, isolated violation.	

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0 115	Continued From page 2 R2 was admitted for services November 19, 2021. On August 15, 2022, at approximately 3:25 p.m., the surveyor interviewed R2 about his stay at the ALF. R2 said he stayed there for short periods of time, usually on the weekend to get a break from his family, but that he often went home to his parents. R2 said staff gave him his medications, meals, and also went on outings with staff to restaurants and the nearby shopping mall. R2 disclosed to the surveyor he would be 18 years old this coming November (2022). R2's Service Plan and Home Health Aide Care Plan, identified as components of the resident service plan, indicated services included medication management, daily meals, socialization/activities, housekeeping and laundry services. On August 16, 2022, at approximately 8:41 a.m., the surveyor observed R2 having breakfast in the dining area. A few minutes later, the surveyor observed unlicensed personnel (ULP)-F administer morning medications to R2. On August 16, 2022, at approximately 11:33 a.m., LALD/RN-E stated R2 was admitted November 19, 2021, and was at the facility for respite care and said R2 was here often two days at a time on weekends, but not every weekend. LALD/RN-E also verified the assisted living services R2 received. LALD/RN-E said she questioned providing services for R2 because he was not 18 but said the Department of Human Services (DHS) said that was not an issue and the as long as the facility had a comprehensive nursing license [licensee's former license type prior to August 1, 2021] they could provide respite care under the HCBS (Home and Community Based Services) designation. LALD/RN-E explained the facility got the HCBS designation to provide respite services once they obtained their	0 115		

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0 115	Continued From page 3 comprehensive license, which they did following the health department survey in April of 2021. LALD/RN-E said after they received the comprehensive license, they transitioned to the assisted living license beginning August 2021 and thought she could continue providing HCBS services under the new, assisted living license. LALD/RN-E stated "there is a conflict" of who we are allowed to serve under this license and understood she would have to discharge R2 because of the resident's age. Licensee's application for assisted living licensure signed by LALD/RN-E on May 19, 2021, indicated LALD/RN-E certified they read and fully understood the Minnesota State statutes governing assisted living licensure. Once the former comprehensive licensed provider converted to an assisted living license, the HCBS designation to the comprehensive license was no longer applicable. Minnesota statute 144G.08, included the following definitions: Subd. (subdivision) 2 defined "adult" as a natural person who has attained the age of 18 years. Subd. 7 indicated an "assisted living facility" means a facility that provides sleeping accommodations and assisted living services to one or more adults. Subd. 59 indicated "resident" means an adult living in an assisted living facility who has executed an assisted living contract. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	0 115		
0 460 SS=F	144G.41 Subdivision 1 Minimum requirements (5) provide a means for residents to request assistance for health and safety needs 24 hours per day, seven days per week; (6) allow residents the ability to furnish and decorate the resident's unit within the terms of the	0 460		

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	36299	A. BUILDING: _____ B. WING _____	08/17/2022

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0 460	Continued From page 4 assisted living contract; (7) permit residents access to food at any time; (8) allow residents to choose the resident's visitors and times of visits; (9) allow the resident the right to choose a roommate if sharing a unit; (10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living facility must not lock a resident in the resident's unit; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide a means for residents to request assistance for health and safety needs 24 hours a day, seven days a week. This had the potential to affect all three residents at the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On August 15, 2022, at approximately 1:40 p.m., the surveyor toured the facility with unlicensed personnel (ULP)-B. The main floor had two living room areas, kitchen, office and a bathroom. The	0 460		

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0 460	Continued From page 5 basement area housed a living room and two vacant resident bedrooms. The 2nd floor had three resident bedrooms, one of which had its own bathroom with shower, and a separate bathroom with shower. None of the bedrooms or bathrooms had a means for residents to call for assistance. ULP-B verified the lack of any call system. On August 15, 2022, at approximately 1:48 p.m., ULP-C stated there was "no call light system like in a nursing home," but added at least one person was present at all times and there were often two staff scheduled, and could handle resident needs. ULP-C said the house was not that big and staff could easily hear if a resident called for help. On August 16, 2022, at approximately 7:25 a.m., licensed assisted living director/registered nurse (LALD/RN)-E said they had a call system when they first opened, found the resident never used it and did not replace it. LALD/RN-E verified that presently there was no call system for residents and stated they could invest in some kind of system. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 460		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet	0 470		

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0 470	Continued From page 6 the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to develop a staffing plan to meet the needs of all residents, and failed to post its daily staffing schedule in a central location accessible to staff, residents, volunteers and the public. This had the potential to affect all three current residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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	0 470		

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0 470	Continued From page 7 of the residents). The licensee held an assisted living facility license. On August 15, 2022, at approximately 1:42 p.m., the surveyor reviewed the main entry and common areas with unlicensed personnel (ULP)-C and found no daily staffing schedule posted. ULP-C verified there was no schedule posted for residents or the public and explained they used a cell phone application called "Home Base" which showed the work schedule that staff could see on their phones. On August 16, 2022, at approximately 9:59 a.m., during the entrance conference, the surveyor requested a copy of the facility's staffing plan from licensed assisted living director/ registered nurse (LALD/RN)-E. LALD/RN-E said they did not have a staffing plan, but showed the surveyor the schedule application "Home Base" and said it was what they used for the schedule. LALD/RN-E said there was no posted schedule and had nothing more documented as far as a staffing plan. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		
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:	0 480		

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0 480	Continued From page 8 (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 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 included document titled, Food and Beverage Establishment Inspection Report dated August 15, 2022, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment	0 550		

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0 550	Continued From page 9 All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities, and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to post required information and contact numbers related to its grievance procedure, contacting the Ombudsmen and for reporting suspected maltreatment. This had the potential to affect all three 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 of the residents). The findings include: On August 15, 2022, at approximately 1:40 p.m., the surveyor toured the facility with unlicensed personnel (ULP)-B. The surveyor did not observe posted contact information for the Office of Ombudsman for Long-Term Care, the Ombudsman for Mental Health and	0 550		

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0 550	Continued From page 10 Developmental Disabilities or the Minnesota Adult Abuse Reporting Center (MAARC). Additionally, there was no information posted regarding the licensee's grievance/complaint procedure, to include name, phone and email contact information of the person from the facility responsible to handle resident concerns. ULP-B verified none of those items were posted in the house. On August 16, 2022, at approximately 10:03 a.m., licensed assisted living director/registered nurse (LALD/RN)-E said she thought the required information and numbers were on the wall and available, but acknowledged they were not. LALD/RN-E said they would need to fix that. The licensee's Reporting Maltreatment of Vulnerable Adult policy, dated as reviewed April 2022, indicated the facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment. The licensee lacked a policy that addressed required postings for the Ombudsmen and its grievance procedure. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
0 570 SS=C	144G.42 Subdivision 1 Display of license The original current license must be displayed at	0 570		

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0 570	Continued From page 11 the main entrance of each assisted living facility. The facility must provide a copy of the license to any person who requests it. This MN Requirement is not met as evidenced by: Based on observation and interview the licensee failed to post its original assisted living license in the main entry of the facility as required, potentially affecting all residents, staff and visitors of the facility. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On August 15, 2022, at approximately 10:15 a.m., the surveyor entered the facility and observed a copy of an assisted living license posted. On August 17, 2922, at approximately 2:13 p.m. during the exit interview, the surveyor observed the licensee's original assisted living licensed posed in the nursing office. Licensed assisted living director/registered nurse (LALD/RN)-E confirmed a copy of the facility license was posted near the entry and the original hung in her office. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 570		

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0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to implement and maintain a quality management program appropriate to the size of the facility and relevant to the type of services provided. This had the potential to affect all residents, staff and visitors of the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On August 16, 2022, at approximately 10:26 a.m., during the entrance conference with licensed	0 580		

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0 580	Continued From page 13 assisted living director/registered nurse (LALD/RN)-E, the surveyor requested to review documentation of the licensee's quality management plan and activities. LALD/RN-E said she reviewed and talked about issues with staff, but acknowledged a lack of any documentation of quality management meetings or what they've done. LALD/RN-E said there was no current, formal plan or documentation. The licensee's Quality Management Program policy, dated as reviewed April 2022, indicated the facility shall develop a continuous quality management program to identify, support and maintain the facility's quality improvement efforts and provide quality services to residents and quality activities would be developed as appropriate and to the size of the facility and the scope of services provided. The policy also indicated quality management data and information will be evaluated by the quality team, would include complaint investigations and resolution, audits of resident records, falls, medication management issues and survey results from health department surveys and quality team findings would be made available to the health department upon request. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 580		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and	0 640		

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0 640	Continued From page 14 suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to support protection and safety by not posting the 911 emergency number in common areas and near telephones provided by the assisted living facility. 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 15, 2022, at approximately 1:40 p.m., the surveyor toured the facility with unlicensed personnel (ULP)-B. There were two phones accessible to residents on the main floor; one was located on the kitchen counter and the other was on a table to the left of the fireplace. A third phone, not readily accessible to residents, was in	0 640		

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0 640	Continued From page 15 the nursing office. There were no emergency numbers or 911 posted at any of the phone locations. ULP-B confirmed the observations. On August 17, 2022, at approximately 10:57 a.m., licensed assisted living director/registered nurse (LALD/RN)-E stated they would post emergency numbers by the phones. The licensee's Reporting Maltreatment of Vulnerable Adult policy, dated as reviewed April 2022, indicated the facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by posting the 911 emergency number in common areas and near telephones provided by the assisted living facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 640		
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	0 660		

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0 660	Continued From page 16 technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC). The licensee failed to ensure TB screening was completed to include either two-step tuberculin skin test (TST) or blood test for one of two employees, unlicensed personnel (ULP)-D, with employee records reviewed. 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: ULP-D was hired March 4, 2021, to provide direct care and services to the licensee's residents. On August 16, 2021, at approximately 7:37 a.m., the surveyor observed ULP-D administer medications to R1. ULP-D's employee record indicated the ULP completed a TB history and symptoms screen and received step one of a TST on April 1, 2021.	0 660		

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0 660	Continued From page 17 The record lacked documentation the TST was read. ULP-D's record lacked evidence of any additional TB screening. On August 17, 2022, at approximately 11:20 a.m., licensed assisted living director/registered nurse (LALD/RN)-E stated they were ertain ULP-C had the skin tests, but verified there was no documentation in the employee's file. LALD/RN-E verified ULP-D had only one step in the record and would investigate and correct it. The licensee's Tuberculosis Screening policy, dated as reviewed April 2022, indicated each employee or volunteer having direct contact with residents must have documentation of baseline health symptom screening prior to providing care to resident. The screening included both assessing for current symptoms of active TB and testing for presence of infection with either a two-step tuberculin skin test or single TB blood test. 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 a TB infection control program should include a facility TB risk assessment. The guidelines also 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." No further information was provided.	0 660		

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	36299	A. BUILDING: _____ B. WING _____	08/17/2022

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0 660	Continued From page 18 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually 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 have a written emergency preparedness plan with all required	0 680		

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0 680	Continued From page 19 content and failed to post an emergency preparedness plan prominently. In addition, the licensee failed to ensure its missing resident plan was reviewed at least quarterly. 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), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on August 16, 2022, at approximately 10:43 a.m., the surveyor requested the licensee's emergency preparedness (EP) plan. Licensed assisted living director/registered nurse (LALD/RN)-E provided the EP plan which included polices from the licensee's general policy book and a computer document titled "Assisted Living Emergency Preparedness Manual," dated July 2021, which was a template for creating a facility EP plan. The EP manual contained a page to document dates when it was revised and updated the plan; it was blank. There was a partially completed hazard vulnerability assessment, but there lacked an analysis and determination of what hazards the facility may face. There was no assessment of the licensee's resident population. Policies and procedures contained in the manual were not tailored to the licensee/facility and included emergency evacuation, sheltering in place, weather emergencies (thunderstorms, tornadoes snow,	0 680		

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0 680	Continued From page 20 cold, heat) and other emergencies (utility disruption, chemical spills, pandemic and civil unrest). The licensee's plan lacked the following required content: -hazard vulnerability assessment; -description of the population served by licensee; -process for emergency preparedness (EP) cooperation with state and local EP officials/organizations; -development of all policies/procedures, based on assessment, and additional policies for: -policies & procedures for handling medical documents; -subsistence needs for staff and patents and sheltering in place; -medical documents; -use of volunteers; and -roles under a waiver declared by the Secretary; -development of a communication plan, including: -names and contact information of staff, resident physicians; -emergency officials contact information; -methods for sharing information; -sharing information on occupancy needs; and -long-term care family notifications; -EP training and testing program; -EP training program for staff (including documentation of training provided); and -annual EP testing requirements. On August 17, 2022, at approximately 2:55 p.m., LALD/RN-E discussed the EP plan with the surveyor. LALD/RN-E acknowledged the plan lacked an overall coherence and confirmed the plan had not been updated or reviewed. LALD/RN-E verified the facility hazard	0 680		

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0 680	Continued From page 21 vulnerability and resident population assessments were incomplete. LALD/RN-E confirmed there was no testing of the plan as required. Additionally, LALD/RN-E confirmed their missing resident plan, reviewed December 17, 2021, had not been more recently reviewed or at least quarterly as required. LALD/RN-E said they would work to revise the plan. The licensee's Emergency Preparedness Manual, Assisted Living Emergency Preparedness Manual, revised July 2021, indicated licensed assisted living establishments must comply with the federal emergency preparedness regulations for long-term care facilities under the Code of Federal Regulations, title 42, section 483.73 or successor requirements. The document indicated the facility would participate in one full-scale, community-based exercise at least annually, and would conduct an additional exercise that would challenge the emergency plan. Further, the facility would analyze its response to and maintain documentation of all drills, exercises and emergency events and revise the plan as needed. The licensee's Emergency Disaster Plan Orientation and Training policy, dated as reviewed April 2022, indicated the facility would develop an EP training program based on the disaster plan and communication and emergency disaster policies and procedures. The training would be provided at least annually. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		

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0 780	Continued From page 22	0 780		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed provide smoke alarms that were interconnected throughout the facility. 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	0 780		

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0 780	Continued From page 23 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 August 17, 2022, at approximately 2:15 p.m. with Licensed Assisted Living Director/ Registered Nurse (LALD/ RN)-E it was observed that the smoke alarms for the facility were not interconnected upon testing. LALD/RN-E visually verified this deficient finding at the time of discovery. 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 provide adequately rated portable fire	0 790		

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0 790	Continued From page 24 extinguishers as required for the facility. 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). Findings include: On a facility tour on August 17, 2022, at approximately 2:15 p.m. with Licensed Assisted Living Director/ Registered Nurse (LALD/ RN)-E it was observed that each of the fire extinguishers provided were 1-A:10-BC rated and did not have at least one 2-A:10-B:C rated fire extinguisher as required by MN Statute 144G.45. LALD/RN-E visually verified this deficient finding at the time of discovery. 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.	0 800		

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0 800	Continued From page 25 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 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). Findings include: On a facility tour on August 17, 2022, at approximately 2:15 p.m. with Licensed Assisted Living Director/ Registered Nurse (LALD/ RN)-E it was observed the electrical receptacle in the upper-level resident bathroom was pulled out of the wall and not secured from movement presenting an electrical hazard. It was also observed that there was a large hole in the flooring on the exterior deck from a deck board that was broken with a portion missing creating a walking hazard for anyone on the deck. LALD/RN-E visually verified these deficient findings at the time of discovery.	0 800		

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0 800	Continued From page 26 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, 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.	0 810		

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0 810	Continued From page 27 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 and failed to provide required employee and resident training on fire safety and evacuation. 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 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 on August 17, 2022, at approximately 1:30 p.m. with Licensed Assisted Living Director/ Registered Nurse (LALD/ RN)-E on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. Record review of the available documentation indicated that the licensee did not maintain the fire safety and evacuation plan for the facility. Review of the document provided titled "What to Do When There is a Fire" dated 2019 indicated that the facility has fire doors held open by magnetic door holders and that tenants are to remain behind the fire doors in the event of a fire. The document also indicated that the fire department will dispatch immediately due to the fire alarm system being directly wired to the fire	0 810		

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0 810	Continued From page 28 station suggesting that the employees or residents do not need to call 911 in the event of a fire. On the facility tour conducted on August 1, 2022, at approximately 2:15 p.m. it was observed that the facility did not have any fire doors or door magnets controlled by the fire alarm system and that the fire alarm system was single station smoke alarms and not a central fire alarm system that is monitored that triggers an automatic response. During interview, LALD/ RN-E acknowledged the inappropriate actions in the plan. Record review of the available documentation indicated that the licensee did not have employee actions to be taken in the event of a fire or similar emergency. During interview, LALD/ RN-E indicated that the fire safety and evacuation plan for the facility lacked these provisions. Record review of the available documentation indicated that the licensee did not have fire protection procedures necessary for residents included in the fire safety and evacuation plan. During interview, LALD/ RN-E indicated that the fire safety and evacuation plan for the facility lacked these provisions. Record review of the available documentation indicated that the fire safety and evacuation plan did not include 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. During interview, LALD/ RN-E indicated that the fire safety and evacuation plan for the facility lacked these provisions. Record review of available documentation indicated that the licensee did not provide	0 810		

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0 810	Continued From page 29 employee training on the fire safety and evacuation plan twice per year after the training it initial hire. Two policies were provided by LALD/ RN-E dated July 2021 and December 2021. Review of the July 2021 policy indicated that employees are required to trained twice per year on fire safety and evacuation. Review of the December 2021 policy indicated that employees are required to received annual training on fire safety and evacuation. During interview, LALD/ RN-E stated that the December 2021 policy is the one that applies since it is the most recent. LALD/ RN-E was not able to provide any further documentation on employee training. Record review of the available documentation indicated that the licensee did not provide annual training to residents who can assist in their own evacuation on the proper actions to take in the event of a fire to include movement, evacuation, or relocation as required by statute. During interview, LALD/ RN-E indicated that the license had not provided any training to the residents in the past year outside of drill participation. A policy on resident training for fire safety and evacuation but requested one was not able to be provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
0 920 SS=C	144G.50 Subd. 2 (c) Contract information (c) The contract must include: (1) a disclosure of the category of assisted living facility license held by the facility and, if the facility is not an assisted living facility with dementia care, a disclosure that it does not hold an assisted living facility with dementia care license; (2) a description of all the terms and conditions of	0 920		

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0 920	Continued From page 30 the contract, including a description of and any limitations to the housing or assisted living services to be provided for the contracted amount; (3) a delineation of the cost and nature of any other services to be provided for an additional fee; (4) a delineation and description of any additional fees the resident may be required to pay if the resident's condition changes during the term of the contract; (5) a delineation of the grounds under which the resident may be discharged, evicted, or transferred or have services terminated; (6) billing and payment procedures and requirements; and (7) disclosure of the facility's ability to provide specialized diets. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written assisted living contract with all required content for one of one resident (R1) with record reviewed. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1's Service Plan and Home Health Aide Care Plan, each dated March 19, 2021, indicated services included: medication management, daily	0 920		

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0 920	Continued From page 31 meals, daily vital signs, daily assistance with bathing and grooming, weekly housekeeping and laundry. R1's Assisted Living Contract, dated and signed by R1 on March 5, 2021, failed to disclose delineation of the cost and nature of any other services provided for an additional fee. On August 17, 2022, at approximately 11:28 a.m., licensed assisted living director/registered nurse (LALD/RN)-E acknowledged the missing content from R1's contract. LALD/RN-E said they used the same contract for all residents and going forward they would use their updated version. The licensee's Assisted Living Contracts policy, dated as reviewed April 2022, indicated the facility will establish a contract with each resident at the time of admission to the program. The policy further indicated the contract must contain all terms concerning the provision of housing, assisted living services and the service plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 920		
0 930 SS=C	144G.50 Subd. 2 (d-e; 1-4) Contract information (d) The contract must include a description of the facility's complaint resolution process available to residents, including the name and contact information of the person representing the facility who is designated to handle and resolve complaints. (e) The contract must include a clear and conspicuous notice of:	0 930		

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0 930	Continued From page 32 (1) the right under section 144G.54 to appeal the termination of an assisted living contract; (2) the facility's policy regarding transfer of residents within the facility, under what circumstances a transfer may occur, and the circumstances under which resident consent is required for a transfer; (3) contact information for the Office of Ombudsman for Long-Term Care, the Ombudsman for Mental Health and Developmental Disabilities, and the Office of Health Facility Complaints; (4) the resident's right to obtain services from an unaffiliated service provider; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written assisted living contract with the required content for one of one resident (R1) with record reviewed. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1's Service Plan and Home Health Aide Care Plan, each dated March 19, 2021, indicated services included: medication management, daily meals, daily vital signs, daily assistance with bathing and grooming, weekly housekeeping and laundry.	0 930		

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0 930	Continued From page 33 R1's Assisted Living Contract, dated and signed by R1 March 5, 2021, failed to include contact information for the Office of Ombudsman for Mental Health and Developmental Disabilities and the Office of Health Facility Complaints. On August 17, 2022, at approximately 11:28 a.m., licensed assisted living director/registered nurse (LALD/RN)-E acknowledged the missing content from R1's contract. LALD/RN-E said they used the same contract for all residents and going forward they would use their updated version. The licensee's Assisted Living Contracts policy, dated as reviewed April 2022, indicated the facility will establish a contract with each resident at the time of admission to the program. Further, the policy indicated the contract must contain all terms concerning the provision of housing, assisted living services and the service plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 930		
0 950 SS=D	144.50 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	0 950		

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0 950	Continued From page 34 "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." (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 document on the assisted living contract the resident's decision to name or decline to name a designated representative for one of one resident (R1) with record reviewed. 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:	0 950		

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0 950	Continued From page 35 The licensee's assisted living contract contained required language that offered the resident opportunity to name a designated representative. On the contract was space to write down and list a designated contact chosen by the resident; and also present was a box for the resident to initial if the resident chooses not to name a representative. R1's Service Plan and Home Health Aide Care Plan, each dated March 19, 2021, indicated services included: medication management, daily meals, daily vital signs, daily assistance with bathing and grooming, weekly housekeeping and laundry. R1's Assisted Living Contract, dated and signed by the resident March 5, 2021, did not list a designated representative, and the box to initial, if resident declined to name a designated representative, was left blank. On August 17, 2022, at approximately 11:37 a.m., licensed assisted living director/registered nurse (LALD/RN)-E reviewed R1's contract and verified there was no designated representative named, nor was the box initialed to indicate R1 declined to name a representative. LALD/RN-E stated it should have been filled out, "it was missed." The licensee's Assisted Living Contracts policy, reviewed April 2022, indicated the facility will establish a contract with each resident at the time of admission to the program. Further, the policy indicated residents have the right to designate a representative before they sign a contract, and the contract must contain a page or space for the name and contact information of the designated representative and a box to initial if they decline to name a representative.	0 950		

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0 950	Continued From page 36 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 950		
01470 SS=F	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 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	01470		

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01470	Continued From page 37 (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 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 received orientation to assisted living facility licensing requirements and regulations with all required content for one of two employees, (unlicensed personnel (ULP)-D) with employee records reviewed. This had potential to affect all three current 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	01470		

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01470	Continued From page 38 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on August 16, 2022, at approximately 10:26 a.m., licensed assisted living director/registered nurse (LALD/RN)-E stated she was familiar with the statutes and regulations for assisting living. LALD/RN-E verified they held an assisted living license, effective August 2021. ULP-D was hired March 4, 2022, to provide direct care services to the licensee's residents. On August 16, 2021, at approximately 7:37 a.m., the surveyor observed ULP-D administer medications to R1. ULP-D's employee record lacked evidence the employee's orientation to assisting living facility requirements included review of the assisted living bill of rights. On August 17, 2022, at approximately 11:00 a.m., licensed assisted living director/registered nurse (LALD/RN)-E verified ULP-C's record lacked orientation on the bill of rights. LALD/RN-E said they used EduCare (a computer-based training system) and missed adding the module for rights as part of orientation. LALD/RN-E stated it was likely the case for all staff and would look to make sure all required modules for orientation were assigned. The licensee's Facility Employee Orientation policy, reviewed April 2022, indicated all	01470		

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01470	Continued From page 39 employees of the assisted living facility would complete an orientation on topics required by Minnesota statutes and rules for assisted living. The policy indicated required orientation must include review of Assisted Living Bill of Rights. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	01470		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned	01650		

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01650	Continued From page 40 consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the service plan included all required content for one of one resident (R1) with record reviewed. This had the potential to affect all three residents who received assisted living services from the licensee. 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: R1's diagnoses included aphasia (difficulty to express written and spoken language) and apraxia (inability to perform actions like dressing) following cerebrovascular disease and failure to thrive. On August 16, 2022, at approximately 7:37 a.m., the surveyor observed unlicensed personnel (ULP)-C administer medications to R1 and later assist R1 with grooming and bathing. R1's service plan, dated March 3, 2019, lacked the following content: -the frequency of each service, according to the resident's current assessment (for bathing); -the identification of staff or categories of staff	01650		

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01650	Continued From page 41 who will provide the services; -the methods of monitoring assessments of the resident; -the schedule and methods of monitoring staff providing services; and -a contingency plan that included: -the action to be taken if the scheduled service cannot be provided. On August 17, 2022, at approximately 11:56 a.m., licensed assisted living director/registered nurse (LALD/RN)-E verified R1's service plan lacked the content described above. LALD/RN-E stated the service plan template was used for all residents, would need to be revised, and all residents would need to get an updated service plan. The licensee's Service Plan policy, dated as reviewed April 2022, indicated all assisted living services will be provided according to a suitable and current written service plan. The policy indicated the service plan included the items listed above. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650		
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The	01730		

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01730	Continued From page 42 facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop an	01730		

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01730	Continued From page 43 individualized medication management record with all required content for one of one resident (R1) with record reviewed. 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: During the entrance conference on August 16, 2022, at approximately July 12, 2022, at 10:40 a.m., licensed assisted living director/registered nurse (LALD/RN)-E confirmed the licensee provided medication management services to all residents at the facility. R1's diagnoses included aphasia (difficulty to express written and spoken language) and apraxia (inability to perform actions like dressing) following cerebrovascular disease and failure to thrive. R1's Service Plan and Home Health Aide Care plan, both dated April 19, 2021, indicated staff provided medication administration daily to R1. On August 16, 2022, at approximately 7:37 a.m., the surveyor observed unlicensed personnel (ULP)-C administer medications to R1. R1's record contained an incomplete Medication Management Services - Addendum to Service Plan document, which listed items and provided	01730		

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01730	Continued From page 44 the nurse space to document required content for R1's medication management plan. R1's medication management plan lacked the following content: -a statement describing the medication management services that will be provided; -a descriptions of storage of medications based on the resident's needs and preferences, risk of diversion and consistent with the manufacturer's directions; -documentation of specific resident instructions relating to the administration of medications; -identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered timely; -procedures for staff notifying an RN or appropriate licensed health professional when a problem arises with medication management services; -any resident-specific requirements relating to documenting medication administration, verification that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. On August 16, 2022, at approximately 4:14 p.m., LALD/RN-E verified R1's record lacked most of the required content for a medication plan. LALD/RN-E said she had the forms, but was unable to explain why R1's plan was not completed. The licensee's Individualized Medication Management Plan and Record policy, reviewed April 2022, indicated the facility would develop an individualized medication management plan and record, based on the nursing assessment and the plan would be part of the service plan. The policy indicated the medication management plan	01730		

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01730	Continued From page 45 included the items listed above. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01790 SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used	01790		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36299	A. BUILDING: _____ B. WING _____	08/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
3CARE HEALTH LLC	6273 WEST 144TH STREET SAVAGE, MN 55378

(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
01790	Continued From page 46 for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse developed written procedures for the unlicensed personnel (ULP) providing medications to residents having unplanned time away when the licensed nurse was not available. This had the potential to affect all three residents. This practice resulted in a level two violation (a	01790		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36299	A. BUILDING: _____ B. WING _____	08/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
3CARE HEALTH LLC	6273 WEST 144TH STREET SAVAGE, MN 55378

(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
01790	Continued From page 47 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on August 16, 2022, at approximately 10:40 a.m., licensed assisted living director/registered nurse (LALD/RN)-E confirmed the licensee provided medication management services to all residents at the facility. The licensee's 7.10 Medication Management - Planned & Unplanned Time Away policy, dated August 1, 2021, indicated for unplanned resident time away when a pharmacist or licensed nurse was not available, the RN could delegate this task to ULP if the RN had developed written procedures for the ULP including any special instructions or procedures regarding controlled substances that were prescribed for the resident. The written procedure must address: - the type of container or containers to be used for the medications appropriate to the provider's medication system; - how the container or containers must be labeled; - written information about the medications to be provided; - how the ULP must document in the resident's record that medications have been provided, including documenting the date the medications where provided and who received the medications, the person who provided the	01790		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36299	A. BUILDING: _____ B. WING _____	08/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
3CARE HEALTH LLC	6273 WEST 144TH STREET SAVAGE, MN 55378

(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
01790	Continued From page 48 medications to the resident, the number of medications that were provided to the resident, and other required information; - how the RN would be notified that medications have been provided and whether the RN needs to be contacted before the medications are given to the resident or the designated representative; - a review by the RN of the completion of this task to verify that this task was completed accurately by the ULP; and - how the ULP must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each medication returned. On August 17, 2022, at approximately 11:18 a.m., LALD/RN-E said she they were aware of the need for a procedure and need to competency test staff regarding resident leave of absence. LALD/RN-E said there was no written procedure and presently no competency testing for unlicensed staff. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790		
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal.	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36299	A. BUILDING: _____ B. WING _____	08/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
3CARE HEALTH LLC	6273 WEST 144TH STREET SAVAGE, MN 55378

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01910	Continued From page 49 (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure documentation of the disposition of medications included all required information for one of one discharged resident (R4) with record reviewed. 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: R4's medication management plan, dated January 12, 2022, identified as part of the service plan, indicated the resident received medication administration services daily. The record indicated R4 received medications for blood pressure, gastro-esophageal reflux and	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36299	A. BUILDING: _____ B. WING _____	08/17/2022

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01910	Continued From page 50 depression. R4's discharge summary, dated Mary 29, 2022, indicated R4 was discharged home with all belongings and with all medications. A discharge document read "I left with all my stuff and medications today, Sunday, May 29th, 2022, at 5:05 p.m." and was signed by R4 and facility staff. R4's discharge record lacked the medications' names, strengths, prescription numbers as appropriate and quantities of medications. On August 17, 2022, at approximately 2:47 p.m., licensed assisted living director/registered nurse (LALD/RN)-E verified the information regarding R4's medications upon discharge was incomplete and said going forward, they will make sure to include all that information when a resident discharged. The licensee's Medication Disposition or Disposal policy, dated as reviewed April 2022, indicated when medication management services have been terminated, staff will document in the resident's record the name of the person to whom the medications were given, the time and date, the name of each medication, dose and the amount of medication remaining. No further information was provided. Time period for correction: Seven (7) days	01910		

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

Type: Full
Date: *08/15/22*
Time: 14:36:41
Report: 8075221157

Food and Beverage Establishment Inspection Report

Location:
3care Health Llc
6273 West 144th Street
Savage, MN55378
Scott County, 70

Establishment Info:
ID #: 0037552
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 9522971393
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.

2-100 Supervision
2-102.12AMN
MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.

No state certified food protection manager.
Comply By: 10/15/22

3-500A Microbial Control: cooling
3-501.13ABC
MN Rule 4626.0380ABC Thaw TCS food by one of the following methods: 1. under mechanical refrigeration that maintains the food temperature at 41 degrees F (4 degrees C) or less; 2. completely submerged under running water at 70 degrees F (21 degrees C) or less with a velocity to remove loose particles on an overflow and the food is maintained at 41 degrees F (5 degrees C) or less; 3. in a microwave oven or; 4. as part of the cooking process.

Frozen meat is reportedly thawed in stagnant water.
Comply By: 08/15/22

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.

No thermometer in garage fridge.
Comply By: 08/29/22

Type: Full
Date: *08/15/22*
Time: 14:36:41
Report: 8075221157
3care Health Llc

Food and Beverage Establishment Inspection Report

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 37 Degrees Fahrenheit - Location: fridge - deli meat
Violation Issued: No

Process/Item: Cold Holding
Temperature: 41 Degrees Fahrenheit - Location: fridge - butter
Violation Issued: No

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

Note: Facility prepares time/temperature control for safety food for same day service. In accordance with MN Rules, part 4626.0506, subpart G, facility is exempt from the equipment requirements of MN Rules, part 4626.0506, subpart A.

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 8075221157 of 08/15/22.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /

Signed:_____
Mercy Kiai
Nurse

Signed: Erin J Tibbetts
Erin Tibbetts
Public Health Sanitarian
Metro District Office
651-201-3987
erin.tibbetts@state.mn.us