



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

November 19, 2024

Licensee

Living Hope Homes Oak Grove

1805 60th Street East

Inver Grove Heights, MN 55077

RE: Project Number(s) SL39718015

Dear Licensee:

This is your **official notice** that you have been **granted your assisted living facility license**. Your license effective and expiration dates remain the same as on your provisional license. Your updated status will be listed on the license certificate at renewal and **this letter serves as proof** in the meantime. If you have not received a letter from us with information regarding renewing your license within 60 days prior to your expiration date, please contact us at (651) 201-5273 or by email at Health.assistedliving@state.mn.us.

The Minnesota Department of Health completed an initial survey on October 16, 2024, for the purpose assessing compliance with state licensing statutes. At the time of the survey, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G.

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

STATE CORRECTION ORDERS

The enclosed State Form documents the state correction orders. The Department of Health documents state correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Home Care 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 are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

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

DOCUMENTATION OF ACTION TO COMPLY

Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the

correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

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

To submit a reconsideration request, please visit:

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

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **<https://forms.office.com/g/Bm5uQEPhVa>**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,



Jodi Johnson, Supervisor
State Evaluation Team
Email: jodi.johnson@state.mn.us
Telephone: 507-344-2730 Fax: 1-866-890-9290

JMD

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39718	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/16/2024
NAME OF PROVIDER OR SUPPLIER LIVING HOPE HOMES OAK GROVE		STREET ADDRESS, CITY, STATE, ZIP CODE 1805 60TH STREET EAST INVER GROVE HEIGHTS, MN 55077			
(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 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: SL39718015-0 On October 14, 2024, through October 16, 2024, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were six residents; six receiving services under the provisional Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
0 470 SS=C	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for	0 470			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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0 470	Continued From page 1 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 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 post a staffing plan with all the required content as indicated in Minnesota Administrative Rule 4659.0180. This had the potential to affect the 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	0 470			

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0 470	Continued From page 2 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings included: During the entrance conference on October 14, 2024, at 12:02 p.m., licensed assisted living director (LALD)-A and clinical nurse supervisor (CNS)-B stated the staffing shift hours were as follows: Day shift: two unlicensed personnel (ULP) 7:00 a.m. - 3:00 p.m.; evening shift: two ULP 3:00 p.m. - 11:00 p.m.; and night shift: two ULP 11:00 p.m. - 7:00 a.m. On October 14, 2024, at 1:00 p.m. the daily staff schedule was observed posted on a white board in a hallway near the front entrance. The staff schedule included how many unlicensed staff were working for the AM, PM, and overnight shift; the schedule did not indicate the specific times of each shift. On October 14, 2024, at 3:55 p.m., LALD-A reviewed the staff schedule and stated the shift times were not included. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) 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: (B) food must be prepared and served according	0 480			

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0 480	Continued From page 3 to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated October 15, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480			
0 550 SS=C	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 email contact information for the individuals who are responsible for handling resident grievances.	0 550			

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0 550	Continued From page 4 The notice must also have the contact information for the 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. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post in a conspicuous place, the email contact information for the individuals responsible for handling resident grievances. This had the potential to affect the licensee's current residents, staff, and visitors. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: On October 14, 2024, at 1:00 p.m., the surveyor toured the facility and observed the posted grievance procedure in the front entrance. The procedure included the name and telephone number for the individual responsible for handling grievances, but it lacked the email contact	0 550			

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0 550	Continued From page 5 information. On October 14, 2024, at 4:00 p.m., licensed assisted living director (LALD)-A stated the form lacked the email contact information and was not aware it wasn't on there. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 550			
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: Based on observation and interview, the licensee failed to support protection and safety by not posting the 911 emergency number in common areas and near telephones provided by the facility as required. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a	0 640			

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0 640	Continued From page 6 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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 October 14, 2024, at 1:00 p.m., the surveyor toured the facility and did not observe the 911 emergency number posted. On October 14, 2024, at 3:50 p.m. licensed assisted living director (LALD)-A stated she thought the 911 emergency number was posted but was unable to locate it. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 640			
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;	0 680			

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0 680	Continued From page 7 (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to practice and document testing of its emergency preparedness (EP) plan at least twice annually as required. This had the potential to affect all residents, staff, and visitors of the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: The licensee's EP plan included documentation of an after-action report/improvement plan from a tabletop scenario titled "Power Outage" dated September 13, 2024, in which seven staff participated. However, the EP plan lacked	0 680			

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0 680	Continued From page 8 evidence the facility had participated in an annual full-scale exercise that is community-based, conducted an annual individual facility-based functional exercise, or experienced an actual natural or man-made emergency that required activation of the emergency plan. On October 16, 2024, at 2:15 p.m. licensed assisted living director (LALD)-A stated the licensee's EP plan lacked the above required component stating she had only conducted the one tabletop scenario as noted above. The licensee's 9.01 Emergency Preparedness Plan - Appendix Z Compliance policy dated August 1, 2021, identified the licensee would conduct, at minimum, two emergency preparedness drills every 12 months - these drills do not include required fire/evacuation drills. One annual exercise will be a full-scale community wide exercise. The second annual exercise will either be a second full-scale community-wide exercise, or a tabletop exercise focused on the assisted living setting. Per Assisted Living Facilities: Minnesota Rules Chapter 4695, 4659.0100, sections A and B, assisted living facilities shall comply with the federal emergency preparedness regulations for long-term care facilities under Code of Federal Regulations, title 42, section 483.73, or successor requirements. This part references documents, specifications, methods, and standards in "State Operations Manual Appendix Z - Emergency Preparedness for All Providers and Certified Supplier Types: Interpretive Guidance," which is incorporated by reference. No further information was provided.	0 680			

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0 680	Continued From page 9	0 680			
0 800 SS=F	TIME PERIOD FOR CORRECTION: Twenty-one (21) days 144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include:	0 800			

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0 800	Continued From page 10 On October 16, 2024, from approximately 10:00 a.m. to 12:10 p.m., the surveyor toured the facility with licensed assisted living director (LALD)-A. The following was observed. The egress window in bedroom three had a section that was cracked. LALD-A stated that a new window was already ordered and was scheduled to arrive on November 12, 2024. There was tape and a piece of cardboard covering the crack, window was still able to be opened. The interior walls had several scraps/dings/scratches and missing or damaged door molding off a couple doors, from wheelchairs hitting them. LALD-A stated that the county was aware and planning to come repair all, but no date had been set. On October 16, 2024, at 11:30 a.m., LALD-A stated they understood the above-listed deficiencies.	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	0 810			

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0 810	Continued From page 11 evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required training and drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include:	0 810			

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER LIVING HOPE HOMES OAK GROVE			STREET ADDRESS, CITY, STATE, ZIP CODE 1805 60TH STREET EAST INVER GROVE HEIGHTS, MN 55077		
(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
0 810	Continued From page 12 On a facility tour with licensed assisted living director LALD-A, on October 16, 2024, from 10:00 a.m. to 12:10 p.m., surveyor observed the posted evacuation plans lacked identification of resident rooms. Resident room numbers on the door are covered with holiday decorations or paperwork. On October 16, 2024, LALD-A provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN: The licensee's FSEP, titled "Fire Policy", undated, failed to include the following: The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The provided FSEP was from a third-party provider and had not been updated to the specific facility. The plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate) but the plan was designed for a building with life safety systems such as fire doors and smoke compartments. The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. The FSEP included standard resident evacuation	0 810			

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0 810	Continued From page 13 procedures but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan included instructions to evacuate residents but did not include any procedures for assisting residents during evacuation nor did it include instructions for staff to follow in case of relocation. On October 15, 2024, at 11:30 a.m., LALD-A stated they understood the areas of their policy that were incomplete and would work on bringing them into compliance. The policy reviewed was an unedited policy purchased from a third-party provider that was not specific to the facility. TRAINING: The licensee failed to provide evacuation training to residents at least once per year. LALD-A lacked documentation showing any training was offered or training was scheduled for a future date for residents on the fire safety and evacuation plan. The licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. The provided records were for fire safety training offered by third-party online software that could not be modified to include the facility-specific fire safety plans. LALD-A was unable to provide documentation showing any training offered or training scheduled for a future date for employees on the fire safety and evacuation plan. On October 16, 2024, at 11:30 a.m., LALD-A stated they understood the requirements for	0 810			

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0 810	Continued From page 14 training residents and staff and would implement a training program that was compliant with statute requirements. DRILLS: The licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month. Record review of licensee's electronic evacuation drill log, undated, indicated evacuation drills were conducted on October 20, 2023, at 10:45 a.m., November 3, 2023, at 11:00 a.m., May 23, 2024, at 3:00 p.m., June 13, 2024, at 10:15 a.m., July 15, 2024, at 1:45 p.m., September 13, 2024, at 12:30 p.m., September 27, 2024, at 1:00 p.m., and October 11, 2024, at 12:00 p.m. No other documentation was provided. On October 16, 2024, at 11:30 a.m., LALD-A stated there were no additional documented drills for the facility. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810			
01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and	01500			

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01500	Continued From page 15 staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training 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 challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or	01500			

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01500	Continued From page 16 (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 annual training included all required topics for each 12 months of employment for one of one employee (unlicensed personnel (ULP)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-C began providing assisted living services on July 31, 2023. On October 14, 2024, at 1:56 p.m. ULP-C was observed to administer medications to R1 in the dining room. ULP-C's employee record lacked documented evidence of the following required annual training: -Training on reporting of maltreatment of vulnerable adults under section 626.557; and -Principles of person-centered planning and service delivery.	01500			

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01500	Continued From page 17 On October 16, 2024, at 2:15 p.m. licensed assisted living director (LALD)-A stated ULP-C's employee filed lacked the required annual training as noted above. The licensee's 5.06 Annual Required Staff Training policy dated August 1, 2021, identified the following training elements MUST be included every 12 months to all staff who perform direct care services: 1. Training on reporting of maltreatment of vulnerable adults under section 626.557; 6. Principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500			
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan.	01760			

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01760	Continued From page 18 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were documented after administration for one of three residents (R3). 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: R3 was admitted on July 3, 2024, with diagnoses that included multiple sclerosis (disease that affects central nervous system), hemiplegia (one-sided paralysis), and vascular dementia (caused by reduced blood flow to brain affecting memory, thinking, and behavior). R3's service plan (private) - Addendum to Contract dated July 3, 2024, indicated R3 received assistance with bathing, dressing, grooming, peri care, catheter care, repositioning, and medication administration. R3's prescriber orders dated June 25, 2024, included: - miconazole (Micatin) (antifungal) 2% powder; apply topically twice daily as needed (PRN) for rash in skin folds; and - moisture barrier ointment; apply twice daily PRN for skin protection or irritation.	01760			

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01760	Continued From page 19 On October 14, 2024, at 2:16 p.m., the surveyor observed unlicensed personnel (ULP)-C and ULP-D sanitize hands, don gloves, gather supplies, and perform peri-cares for R3. R3's peri area was cleansed using disposable wipes, washrag, soap, water, and dried. ULP-D stated R3's peri area was red, changed gloves, obtained R3's miconazole nitrate powder, and lightly dusted the medication to R3's peri and groin fold areas. In addition, ULP-C changed gloves and applied Calmoseptine cream (identified as house stock moisture barrier ointment) to R3's bilateral buttocks stating it was applied as a protectant for her skin. ULP-C and ULP-D proceeded to position R3, removed gloves, and sanitized hands. ULP-D did not document the administration of the miconazole nitrate powder and ULP-C did not document the administration of the moisture barrier ointment, both indicating it was part of R3's routine peri cares. R3's Medication Administration Summary dated October 1, 2024, through October 15, 2024, did not include documentation of miconazole 2% powder or moisture barrier ointment (house stock). On October 15, 2024, at 1:09 p.m., clinical nurse supervisor (CNS)-B stated documentation of the PRN miconazole nitrate powder and Calmoseptine cream medication administration had not been completed. CNS-B stated documentation should be completed after any medication administration. The licensee's 7.08 Medication Management - Administration & Set up policy dated August 1, 2021, noted nursing staff and unlicensed personnel trained to provide medication	01760			

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01760	Continued From page 20 administration would document any medication administration provided accurately in each resident record. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760			
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: Based on interview and record review, the licensee failed to document in the resident's record the disposition of a medication including the medication's name, strength, prescription	01910			

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01910	Continued From page 21 number as applicable, quantity, date of disposition, and names of staff and other individuals involved in the disposition for one of one discharged resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: The licensee's discharged resident roster dated October 14, 2024, indicated R2 was admitted on May 21, 2024, and expired on May 22, 2024. R2's Medication Administration Summary dated May 21, 2024, at 6:33 p.m. included documentation of administration of atropine 1% eye drops (used to treat excessive secretions in patients at end of life); place two drops under the tongue every 4 hours as needed for secretions. R2's Medication Disposition dated May 24, 2024, included two medications for anxiety and two medications for shortness of breath and/or pain. R2's record lacked evidence of documentation of the disposition of atropine eye drops to include: name of the medication, strength, prescription number if applicable, quantity, to whom the medications were given, date of disposition, and the names of the staff and other individuals involved in the disposition. On October 14, 2024, at 3:28 p.m., clinical nurse supervisor (CNS)-B stated R2 was admitted for	01910			

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01910	Continued From page 22 end-of-life care and the licensee had provided medication management. CNS-B stated R2's record did not include documentation of atropine eye drop disposition as noted above. CNS-B further stated she had disposed of the atropine eye drops on the same day as the other listed medications but did not document it. CNS-B further added the acetaminophen suppository administered to R2 had been house stock. The licensee's 7.23 Medication Disposal policy dated August 1, 2021, included the facility would dispose of any medications remaining with the facility upon the resident's death according to state and federal regulations for disposition of medications and controlled substances. 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. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910			
02310 SS=D	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced	02310			

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02310	Continued From page 23 by: Based on observation, interview, and record review, the licensee failed to ensure the care and services were provided according to acceptable health care and medical, or nursing standards for one of one resident (R1) related to oxygen storage. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On October 14, 2024, at 1:15 p.m., the surveyor observed an unsecured oxygen cylinder sitting alongside the wall on the floor of the main hallway, next to a running oxygen concentrator. On October 15, 2024, at 8:58 a.m., the surveyor observed two unsecured oxygen cylinders sitting on the floor next to a running oxygen concentrator in R1's room. At this time, clinical nurse supervisor (CNS)-B stated the oxygen cylinders were unsecured and indicated they could be easily tipped over. CNS-B further stated she did not have an oxygen rack or chains to secure the cylinders and would need to ask the oxygen company for something to prevent them from falling over. The Minnesota Department of Health Oxygen Cylinder Storage Requirements dated April 16, 2020, indicated cylinders must be secured	02310			

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02310	Continued From page 24 (chains or racks) to prevent them from falling over. The licensee's 7.40 Oxygen policy dated August 1, 2021, indicated: 4. When possible, keep oxygen cylinders and vessels a minimum of five feet from electrical appliances 7. Keep oxygen cylinders and vessels in a well-ventilated area (not in closets, behind curtains, or other confined space). The small amount of oxygen gas that is continually vented from these units can accumulate in a confined space and become a fire hazard. 8. Oxygen cylinders and vessels must remain upright at all times. Never tip an oxygen cylinder or vessel on its side or try to roll it to a new location. No additional information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	02310			

Type: Full
Date: 10/15/24
Time: 10:54:16
Report: 1036241217

Food and Beverage Establishment Inspection Report

Page 1

Location:

LIVING HOPE HOMES OAK GROVE
1805 60TH STREET EAST
Inver Grove Heights, MN55075
Dakota County, 19

Establishment Info:

ID #: 0043713
Risk:
Announced Inspection: No

License Categories:

Expires on: 12/31/24

Operator:

Phone #:
ID #:

The violations listed in this report include any previously issued orders and deficiencies identified during this inspection. Compliance dates are shown for each item.

The following orders were issued during this inspection.

3-300B Protection from Contamination: cross-contamination, eggs

3-302.11A(1) **** Priority 1 ****

MN Rule 4626.0235A(1) Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.

OBSERVED EGGS BEING STORED OVER RTE FOODS IN THE KITCHEN FRIDGE. DISCUSSED PROPER FOOD STORAGE WITH STAFF.

Comply By: 10/22/24

Surface and Equipment Sanitizers

UTENSIL SURFACE TEMP: = at 160 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Hold/MILK
Temperature: 40 Degrees Fahrenheit - Location: WHIRLPOOL FRIDGE
Violation Issued: No

Process/Item: Ambient Temp
Temperature: 38 Degrees Fahrenheit - Location: WHIRLPOOL FRIDGE
Violation Issued: No

Process/Item: Ambient Temp
Temperature: 0 Degrees Fahrenheit - Location: WHIRLPOOL FREEZER
Violation Issued: No

Type: Full
Date: 10/15/24
Time: 10:54:16
Report: 1036241217

Food and Beverage Establishment Inspection Report

Page 2

LIVING HOPE HOMES OAK GROVE

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

THIS INSPECTION WAS CONDUCTED IN CONJUNCTION WITH MDH HEALTH REGULATORY DIVISION (HRD) SURVEY. SURVEYOR FROM HRD WAS SUSAN KAILS. INSPECTION CONDUCTED IN PRESENCE OF KELLI DIXON, THE PERSON IN CHARGE. AT TIME OF INSPECTION, ESTABLISHMENT HAD SIX RESIDENTS. ALL VIOLATIONS WERE DISCUSSED WITH THE SURVEYOR AND PERSON IN CHARGE DURING INSPECTION.

THIS FACILITY DOES NOT HAVE COMMERCIAL GRADE ANSI EQUIPMENT. ALL FOOD MUST BE SERVED THE SAME DAY IT IS PREPARED, AND LEFTOVERS CAN NEVER BE SAVED.

FOOD SERVICE AREA FLOORS, WALLS, CEILINGS, COUNTERTOPS, AND FINISH MATERIALS MUST BE NON-ABSORBANT, SMOOTH, DURABLE, AND EASILY CLEANABLE. CEILINGS CANNOT HAVE POPCORN TEXTURE. CABINETS CANNOT HAVE HOLLOW BASES. EXPOSED WOOD IS NOT APPROVED FOR FOOD SERVICE AREAS. WOOD IS NOT AN APPROVED FOOD CONTACT SURFACE.

ADDITIONAL TOPICS DISCUSSED WITH THE PERSON IN CHARGE:

- EMPLOYEE ILLNESS LOG AND EXCLUSION POLICY.
- HAND WASHING POLICY AND REVIEW.
- PROPER FOOD STORAGE.
- GLOVE USAGE.
- THERMOMETER USE AND CALIBRATION.
- SANITIZER USE AND TEST KITS.
- DATE MARKING.
- PEST CONTROL.
- FULLY COOKING FOOD FOR HIGH RISK POPULATIONS.
- ANSI 184 STANDARD FOR RESIDENTIAL DISH WASHER.

FOR CORRECT BY DATES REFER TO COMPLETE REPORT ISSUED BY HRD.

****IF ANY RESIDENT COMPLAINS OF ILLNESS, CONTACT THE MINNESOTA DEPARTMENT OF HEALTH AND PROVIDE THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER TO THE CUSTOMER. THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER IS 1-877-366-3455.**

Type: Full
Date: 10/15/24
Time: 10:54:16
Report: 1036241217

LIVING HOPE HOMES OAK GROVE

Food and Beverage Establishment Inspection Report

Page 3

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

I acknowledge receipt of the inspection report number 1036241217 of 10/15/24.

Certified Food Protection Manager: KELLI MARTESE DIXON

Certification Number: FM120598 Expires: 11/06/26

Inspection report reviewed with person in charge and emailed.

Signed: _____

KELLI DIXON
PERSON IN CHARGE

Signed: _____

Jeff Johanson