DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF CONDITIONAL LICENSE

Electronically Delivered

July 1, 2024

Licensee
Our Caring Hands LLP
9220 207th Street West
Lakeville, MN 55044

RE: Conditional License Number 415235
Health Facility Identification Number (HFID) 34952
Project Number(s) SL34952015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on May 17, 2024, for the purpose of assessing compliance with state licensing statutes. Based on the survey results you were found not to be in substantial compliance with the laws pursuant to Minnesota Statutes, Chapter 144G.

As a result, pursuant to Minn. Stat. § 144G.20, MDH is issuing a 90-day conditional license due to expire on **September 29, 2024**.

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

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

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

In accordance with Minn. Stat. § 144G.31, Subd. 4(a)(5), MDH may impose fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. MDH may impose a fine of $1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to

Minn. Stat. § 626.5572, Subds. 2, 9, 17. MDH also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

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

MDH may assess fines based on the level and scope of the orders outlined below. The total amount of **potential** fines that may be assessed related to these correction orders is $12,000.00. **MDH is not imposing these fines against your license at this time.**

St - 0 - 0470 - 144g.41 Subdivision 1 - Minimum Requirements - $3,000.00
St - 0 - 0820 - 144g.45 Subd. 2 (g) - Fire Protection And Physical Environment- $3,000.00
St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required- $3,000.00
St - 0 - 1620 - 144g.70 Subd. 2 (c-E) - Initial Reviews, Assessments, And Monitoring- $3,000.00

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders and immediately correct any reissued orders outlined on the state form; however, plans of correction are not required to be submitted for approval. **If corrections are not made, MDH may impose fines as described above and in accordance with Minnesota Statutes 144G.**

The correction order documentation should include the following:

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

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

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

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

CONDITIONAL LICENSE ISSUED:
MDH will issue Our Caring Hands LLP a conditional assisted living facility license for 90 calendar days from the date of this notice. At an unannounced point in time, within the 90 calendar days, MDH will conduct a

follow-up survey, as defined in Minn. Stat. § 144G.30, Subd. 6. Based on the results of the follow-up survey, MDH will determine if Our Caring Hands LLP is in substantial compliance.

The following conditions apply on the conditional assisted living facility license:

a. **No new substantiated maltreatment allegations:** If any new investigations begin in the conditional license period, and the allegations are substantiated, MDH may pursue additional enforcement actions up to and including immediate temporary suspension and revocation of the license.

b. **No new admissions:** Our Caring Hands LLP will not admit any new residents under its conditional assisted living facility license until MDH removes the "no new admissions" condition. Our Caring Hands LLP must provide the Department:

   i. A list of the names and birthdates of any individuals Our Caring Hands LLP is currently in the process of admitting. These individuals will be able to continue the admittance process.

   ii. A list of all current residents by location including:
      1. Name and birthdate of each resident
      2. Physical location of each resident
      3. Current payment source for services
      4. If Elderly Waiver, the name and contact information of the care coordinator/case manager
      5. If the resident is not able to make informed decisions, the name of their representative and how to contact the representative

c. **Consultant:** Our Caring Hands LLP will contract with an RN to provide consultation concerning all resident(s) to whom Our Caring Hands LLP provides licensed assisted living services under the conditional license. <u>The consultant must have access to all resident(s) receiving services from Our Caring Hands LLP. The consultant will conduct initial and ongoing evaluations of the provider. Direct resident observation may be required based on the consultant's judgement or at the discretion of MDH</u>. The RN must not have any affiliation with Our Caring Hands LLP and MDH must review the RN's credentials and approve the selection. Our Caring Hands LLP is responsible for the expense of the contract with the RN. The main purpose of the consultant is to provide guidance to Our Caring Hands LLP in an effort to help Our Caring Hands LLP align their practices with the requirements of Minn. Stat. §§ 144G.01 – 144G.9999 and to provide oral and written reports to MDH noting progress toward substantial compliance and/or concerns about observations. Our Caring Hands LLP will develop and implement policies, procedures, and processes specific to the offered services in accordance with the guidance provided by the consultant to ensure ongoing monitoring and substantial compliance with statutory requirements.

d. **Reports:** The RN consultant will provide MDH with regular reports at intervals specified by MDH. Reports will begin on a weekly basis until MDH notifies Our Caring Hands LLP and the RN consultant about a change. Each report will be electronically submitted to Casey DeVries, Surveyor Supervisor, State Evaluation Team, Health Regulation Division,

at Casey.DeVries@state.mn.us. Casey DeVries can be reached at 651-201-5917 (office) with questions about reports. The content of the reports will include information such as:

i. Progress towards correction of orders;
ii. Observations of staff delivering assisted living services and the level of competency observed;
iii. Conversations with residents and family members about satisfaction with assisted living services;
iv. Conversations with staff about their level of knowledge about the tasks they perform, the people they serve and the health professionals who delegate to them;
v. Overall impressions about the quality of the assisted living services delivered;
vi. Overall impressions about the dignity with which the residents and their family members are treated;
vii. Concerns; and
viii. Any other information requested by the Department or considered important by the RN consultant(s).

e. **Monitoring visits:** MDH may make unannounced monitoring visits to assess the progress of Our Caring Hands LLP to correct the violations cited during the survey as well as to determine the overall practice of Our Caring Hands LLP in meeting the needs of the people it serves. In addition, the Office of Ombudsman for Long-Term Care (OOLTC) may also make unannounced monitoring visits to determine the level of satisfaction of those people who receive licensed assisted living services. The OOLTC will share their findings with MDH.

f. **Follow-up survey:** At the time of the follow-up survey, MDH may pursue additional enforcement actions, up to and including immediate temporary suspension or revocation of the license if MDH identifies any level 3 or 4 violations or widespread care related violations.

g. **Corrective Action Plan:** Our Caring Hands LLP will develop and work within a corrective action plan (CAP). The CAP is a working document that includes at least the following information:

i. A statement of the concern
ii. A description of what will happen to correct the concern
iii. A target date for when each correction will be complete
iv. Who is responsible to make sure it happens
v. Current status of correction work
vi. Description of a plan to monitor and ensure ongoing substantial compliance for each corrected order

RESULTS OF FOLLOW-UP EVALUATION DURING THE CONDITIONAL LICENSE PERIOD:
MDH will determine if Our Caring Hands LLP is in substantial compliance based on the results of the follow up survey. MDH will make this determination within the 90-day conditional license period. If MDH determines Our Caring Hands LLP is in substantial compliance on the follow up survey, MDH will remove the conditions from Our Caring Hands LLP's assisted living facility license, and Our Caring Hands LLP will correct any outstanding

violations identified during the survey. If Our Caring Hands LLP is not in substantial compliance on the follow-up survey, MDH may take additional enforcement action, up to and including immediate temporary suspension and revocation, as authorized by Minn. Stat. § 144G.20.

REQUESTING A HEARING:
Pursuant to Minn. Stat. §144G.20, Subd. 18, the licensee may appeal an action against the license under this section. The licensee must request a hearing no later than 15 business days after licensee receives notice of the action. To submit a hearing request, please visit **https://forms.web.health.state.mn.us/form/HRD-Appeals-Form**.

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 Casey DeVries directly at: 651-201-5917.

Sincerely,

Rick Michals, J.D.
Interim Assistant Division Director

Minnesota Department of Health
Health Regulation Division

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34952	A. BUILDING: _____ B. WING _____	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR CARING HANDS LLP	9220 207TH STREET WEST LAKEVILLE, MN 55044

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL34952015-0 On May 13, 2024, through May 17, 2024, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were five residents, five of five residents received services under Assisted Living license. Immediate orders for correction were identified on May 13, 14, 15, and 16, 2024, issued for SL34952015-0, tag identification 470, 1290, 2310, and 1620, respectively. On May 14, 2024, the immediacy of correction order 470 was removed, however non-compliance remained, and the scope and level remained unchanged. On May 16, 2024, the immediacy of correction order 1290 was removed, however	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	

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0 000	Continued From page 1 non-compliance remained, and the scope and level remained unchanged. On May 16, 2024, the immediacy of correction order 2310 was removed, however non-compliance remained, and the scope and level remained unchanged. The immediacy of 1620 was not removed at the time of exit on May 17, 2024, at 11:25 a.m.	0 000		
0 250 SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's	0 250		

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0 250	Continued From page 2 residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4, or interferes with or impedes access by the Office of Ombudsman for Mental Health and Developmental Disabilities according to section 245.94, subdivision 1; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to show they met the requirements of licensure, by attesting the managerial officials who oversaw the day-to-day operations understood applicable statutes and rules; nor developed and/or implemented current policies and procedures as required with records reviewed. This had the potential to affect all residents, staff, and visitors.	0 250		

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0 250	Continued From page 3 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: During the entrance conference on May 13, 2024, at 9:30 a.m., licensed assisted living director/owner (LALD/O)-D and clinical nurse supervisor (CNS)-C stated the licensee's employees in charge of the facility were familiar with the assisted living regulations and the licensee provided medication and treatment management services. The licensee's Application for Assisted Living License, section titled Official Verification of Owner or Authorized Agent, (page 17 and 18 of the application), identified, I certify I have read and understand the following: [a check mark was placed before each of the following]: - I have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section] 144G.45, my building(s) must comply with subdivisions 1-3 of the section, as applicable section Laws 2020, 7th Spec. [special] Sess [session]., chpt. [chapter] 1. art. [article] 6, sect. 17. - I have read and fully understand Minn. Stat. sect. 144G.80, 144G.81. and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22, my	0 250		

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0 250	Continued From page 4 building(s) must comply with these sections if applicable. - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G. - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659. - Reporting of Maltreatment of Vulnerable Adults. - Electronic Monitoring in Certain Facilities. - I understand pursuant to Minn. Stat. sect. 13.04 Rights of Subjects of Data, the Commissioner will use information provided in this application, which may include an in-person or telephone conference, to determine if the applicant meets requirements for assisted living licensing. I understand I am not legally required to supply the requested information; however, failure to provide information or the submission of false or misleading information may delay the processing of my application or may be grounds for denying a license. I understand that information submitted to the commissioner in this application may, in some circumstances, be disclosed to the appropriate state, federal or local agency and law enforcement office to enhance investigative or enforcement efforts or further a public health protective process. Types of offices include Adult Protective Services, offices of the ombudsmen, health-licensing boards, Department of Human Services, county or city attorneys' offices, police, local or county public health offices. - I understand in accordance with Minn. Stat. sect. 144.051 Data Relating to Licensed and Registered Persons (opens in a new window), all data submitted on this application shall be	0 250		

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0 250	Continued From page 5 classified as public information upon issuance of a provisional license or license. All data submitted are considered private until MDH issues a license. - I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659 governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. - I have examined this application and all attachments and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct, and complete. I will notify MDH, in writing, of any changes to this information as required. - I attest to have all required policies and procedures of Minn. Stat. chapter 144G and Minn. Rules chapter 4659 in place upon licensure and to keep them current as applicable. Page 18 was electronically signed by authorized agent administrator (LALD/O)-D on December 13, 2023. The licensee had an Assisted Living license issued on January 25, 2024, with an expiration date of January 24, 2025. The licensee failed to ensure the following policies and procedures were developed and/or	0 250		

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0 250	Continued From page 6 implemented: (1) conducting and handling background studies on employees; (2) orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; (3) conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate; (4) orientation to and implementation of the assisted living bill of rights; (5) infection control practices; (6) conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards; (7) delegation of tasks by registered nurses or licensed health professionals; As a result of this survey, the following orders were issued 0250, 0470, 0480, 0510, 0570, 0640, 0650, 0660, 0680, 0810, 0820, 0950, 1290, 1370, 1380, 1470, 1620, 1790, 1820, 1880, 1890, 2310, and 2410 indicating the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.08 to 144G.95. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 250		
0 470 SS=I	144G.41 Subdivision 1 Minimum requirements	0 470		

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0 470	Continued From page 7 (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 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, interview, and record review, the licensee failed to ensure sufficient staffing to meet the needs of three of three residents (R1, R2, R3), who required two-person transfers with a mechanical lift. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death,	0 470		

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0 470	Continued From page 8 or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee lacked sufficient staffing to meet R1, R2 and R3's needs on a 24-hour basis as required by the Care Schedule for Daily Living Activities. The licensee's employee schedule from May 13, 2024, to May 26, 2024, indicated one unlicensed personnel (ULP) for day shift (7am to 7pm) and one ULP for night shift (7pm to 7am) with no indication of an on-call staff person. R1 R1's diagnoses included quadriplegia, unspecified injury at C1 level of cervical spinal cord, anxiety disorder, border line personality disorder bradycardia, hypotension, and pain. R1's Resident Care Schedule for Daily Living Activities update January 2, 2024, indicated R1 required a two plus (2+) person assist for transfers. R1's 90-day Service Plan Re-assessment and Monitoring form dated May 2, 2024, indicated R1 was non ambulatory, but did not indicate how R1 was transferred and how many ULPs were needed to transfer R1. R1's Resident Enrollment Information dated March 1, 2024, indicated R1's area of concerns were ambulation, disability, incontinence,	0 470		

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	34952	A. BUILDING: _____ B. WING _____	05/17/2024

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0 470	Continued From page 9 behavioral issues, and mental health. R2 R2's diagnoses included diabetes mellitus, personality disorder, morbid obesity, anxiety disorder severe, persistent asthma, agitation, depressive disorder, and overactive bladder. R2's Resident Care Schedule for Daily Living Activities update April 11, 2024, indicated R2 required two plus (2+) person assist to be transferred to electric wheelchair, may do one plus (1+) assist to return to bed. R2's 90-day Service Plan Re-assessment and Monitoring form dated May 2, 2024, indicated R2 was non ambulatory, but did not indicate how R2 was transferred and how many ULPs were needed to transfer R2. R2's Resident Enrollment Information dated September 20, 2022, indicated R2's area of concerns were ambulation, disability, behavioral issues, and mental health. R3 R3's diagnoses included acquired absence of the right leg below the knee, morbid obesity, hypertension, and diabetes mellitus. R3's Resident Care Schedule for Daily Living Activities update January 14, 2024, indicated R3 required two plus (2+) person assist to be transferred to wheelchair, may do one plus (1+) assist to return to bed. R3's 90-day Service Plan Re-assessment and Monitoring form dated May 2, 2024, indicated R3 was non ambulatory, but did not indicate how R3 was transferred and how many ULPs were	0 470		

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0 470	Continued From page 10 needed to transfer R3. R3's Resident Enrollment Information dated October 2, 2023, indicated R3's area of concerns were ambulation, disability, behavioral issues, and mental health. On May 13, 2024, at 10:09 a.m., during the entrance conference, licensed assisted living director/owner (LALD/O)-D stated one ULP was scheduled from 7:00 a.m. to 7:00 p.m., and one ULP was scheduled from 7:00 p.m. to 7:00 a.m. LALD/O-D stated either themselves or their son and daughter will come in to help with two-person assist when transfer is needed. LALD/O-D stated they all live 5 to10 minutes away from the facility. Clinical nurse supervisor (CNS-C) and LALD/O-D stated they did not have staffing plan, but they did have a biweekly staffing schedule. On May 13, 2024, at 11:36 a.m., LALD/O-D stated out of the three residents, two of them were incontinent and they do not call for bowel movements as they do not have the sensation, staff has to check and change them. If residents asked to be changed, staff would call LALD/O-D and residents have wait until LALD/O-D or their son and daughter arrives at the facility. LALD/O-D also stated, "We cannot afford to pay another staff to come and help them for 12 hours, we do not get paid that much." LALD/O-D stated in case of emergency, staff are expected to call 911 and do what their instinct tells them to do. On May 13, 2024, at 12:04 p.m., ULP-A stated nobody uses the bathroom at night, but if they do, they will call LALD/O-D for help, if it is emergency, the ULPs call 911. On May 13, 2024, at 12:12 p.m., CNS-C stated all	0 470		

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0 470	Continued From page 11 mechanical lift transfers are two persons assist but one person can do mechanical lift transfer when putting R2 back to bed. CNS-C stated in case of emergency, one person can do the transfer with mechanical lifts. On May 13, 2024, at 12:40 p.m., R2 stated they get transferred by two people or one person depending on the ULP. R2 also stated they had diarrhea yesterday (May 12, 2024), they asked to be changed and they had to wait at least half hour to get changed. On May 13, 2024, at 2:30 p.m., the surveyor inquired to know if the licensee has a toileting schedule for residents who are incontinent and with no sensation. LALD/O-D stated the licensee did not have a toileting schedule written but staff know to check and change residents every two hours. Minnesota Administrative Rule 4659.0180, Subpart 5 dated August 11, 2021, indicated "A minimum of two direct-care staff must be scheduled and available to assist at all times whenever a resident requires the assistance of two direct-care staff for scheduled reasonably foreseeable and unscheduled needs, as reflected in the resident's assessments and service plan." The undated manufacturer recommendation for Bestcare Hoyer Lift read, "whenever possible, two caregivers should be present during lifting and transferring." No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE	0 470		

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0 480	Continued From page 12	0 480		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a 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 May 13, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 510 SS=D	144G.41 Subd. 3 Infection control program	0 510		

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0 510	Continued From page 13 (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an effective infection control program that complied with accepted health care, medical and nursing standards for infection control related to gloving and hand hygiene for one of two unlicensed personnel (ULP), licensed assisted living director/owner who is also ULP ((LALD/O)-D). 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 May 17, 2024, at 9:00 a.m., the surveyor observed LALD/O-D provide morning cares to	0 510		

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0 510	Continued From page 14 R3. LALD/O-D had gloves on both hands. The surveyor observed a small open wound on R3's left buttock and reddened areas on both buttocks. LALD/O-D washed off the buttocks with wound cleanser, applied calmoseptine ointment without changing gloves, and applied the ointment to R3's peri (private) area without changing gloves. LALD/O-D then removed the glove on the right hand, disposed of it and fixed R3's brief without a glove on the right hand. LALD/O-D applied a new glove to the right hand without changing the glove on the left hand, washed R3's left leg with wound cleanser and applied ketoconazole cream in between the left leg toes and applied lotion to the left lower leg. LALD/O-D then removed gloves, disposed of them, and helped R3 with rearranging the bed without performing hand hygiene. LALD/O-D left the room with the two creams mentioned above, locked them up in the medication cabinet, which was located in the kitchen, went back to R3's room without performing hand hygiene, came out of R3's room and then performed hand hygiene. On May 17, 2024, at 9:15 a.m., LALD/O-D stated they did receive infection control training to wash their hands and change their gloves when they go from one body part to the other. LALD/O-D stated they were trained to change both gloves, but they kept the glove on their left hand because it was clean, and they did not touch anything; "I should have known better, I should have changed both, we are trained that way." LALD/O-D also stated they should have changed gloves after performing wound care on the buttocks and use new pair of gloves for performing peri-area cares; "I tell my staff to change it all the time but here I am being watched not doing the right thing." LALD/O-D stated they should have performed hand hygiene every time they changed gloves	0 510		

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0 510	Continued From page 15 and before they left the room. On May 17, 2024, at 9:15 a.m., clinical nurse supervisor (CNS)-C stated gloves are supposed to be changed from one patient to the other and need to be changed if they are soiled. CNS-C stated their expectation for ULPs on performing hand hygiene was before they cleaned the wound and after they finish the entire wound care. "I do not expect them to wash hands in between cares, they do not have to put resident on [their] side and go wash." The surveyor inquired about hand sanitizers in the rooms or if the ULPs could bring hand sanitizers to the rooms, CNS-C stated, "that would be nice and quick enough." The CDC Guideline for Hand Hygiene Guidance in Healthcare Settings on the CDC website last reviewed on January 20, 2020, read, "The Core Infection Prevention and Control Practices for Safe Care Delivery in All Healthcare Settings recommendations of the Healthcare Infection Control Practices Advisory Committee (HICPAC) include the following strong recommendations for hand hygiene in healthcare settings. Healthcare personnel should use an alcohol-based hand rub or wash with soap and water for the following clinical indications: - Immediately before touching a patient - Before performing an aseptic task (e.g., placing an indwelling device) or handling invasive medical devices - Before moving from work on a soiled body site to a clean body site on the same patient - After touching a patient or the patient's immediate environment - After contact with blood, body fluids, or contaminated surfaces - Immediately after glove removal Healthcare facilities should:	0 510		

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0 510	Continued From page 16 - Require healthcare personnel to perform hand hygiene in accordance with Centers for Disease Control and Prevention (CDC) recommendations - Ensure that healthcare personnel perform hand hygiene with soap and water when hands are visibly soiled - Ensure that supplies necessary for adherence to hand hygiene are readily accessible in all areas where patient care is being delivered Unless hands are visibly soiled, an alcohol-based hand rub is preferred over soap and water in most clinical situations due to evidence of better compliance compared to soap and water. Hand rubs are generally less irritating to hands and, in the absence of a sink, are an effective method of cleaning hands." The licensee's undated Standard Precaution for All Healthcare Workers policy, read, " 1. Assume that blood and all body fluids, with or without visible blood, from all residents are potentially infectious. 2. WASH HANDS 3. GLOVES, such as vinyl or latex medical gloves, must be worn when cleaning reusable equipment; when having direct contact with blood, body fluids, mucous membranes or non-intact skin; when handling items soiled with blood; or when handling equipment contaminated with blood or body fluids. This includes, but is not limited to the following: a. Suctioning procedures b. Catheter care and removal of catheters c. Dressing changes d. Handling of grossly contaminated linens e. Collection and emptying of all suction and drainage devices e.g., Foley catheter bags, suction machines, and hemovacs f. Starting and discontinuing intravenous	0 510		

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0 510	Continued From page 17 infusions g. Providing oral hygiene h. Enema administration i. Cleaning resident rooms, bathrooms, emptying trash, or changing linens on resident's bed j. Venipuncture or other vascular access procedures Gloves should be changed after each resident contact. When gloves are removed, thorough hand washing is required. Gloves do not take the place of hand washing. If glove is torn or needle stick or other injury occurs, the gloves should be removed, hands washed well, and a new glove used as promptly as resident safety permits." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
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: Based on observation and interview, the licensee failed to display the original current license at the main entrance of the assisted living facility as required. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level one violation (a violation that has no potential to cause more than	0 570		

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0 570	Continued From page 18 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 May 13, 2024, at 11:09 a.m., during the facility tour, surveyor observed assisted living license expired on January 31, 2024, posted on the wall by the main entrance. On May 13, 2024, at 11:09 a.m., licensed assisted living director/owner (LALD/O)-D stated they forgot to post the new license and they stated they would replace it with the new license. On May 13, 2024, at 4:00 p.m., upon exiting the facility, surveyor observed the new license posted on the wall by the main entrance. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 570		
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	0 640		

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0 640	Continued From page 19 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 post 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 May 13, 2024, at 11:07 a.m., during the facility tour with licensed assisted living director/owner (LALD/O-D), the surveyor observed a landline phone on the kitchen counter by the refrigerator, which lacked the required posting of the 911 emergency number. On May 13, 2024, at approximately 11:10 a.m., LALD/O-D stated they had the 911 number posted somewhere but was unable to find it anywhere in the kitchen, dining room, or the living room. On May 14, 2024, at 9:00 a.m., unlicensed	0 640		

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0 640	Continued From page 20 personnel (ULP)-A stated the phone was used by residents and staff. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 640		
0 650 SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employee records	0 650		

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0 650	Continued From page 21 included all required content for one of three employees (clinical nurse supervisor (CNS)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: The licensee's Assisted Living Staff Roster indicated CNS-C was hired August 1, 2021. CNS-C provided supervision to staff and direct care services to residents. CNS-C's employee file lack the following content; -copy of the registered nurse license. On May 16, 2024, at 12:39 p.m., licensed assisted living director (LALD/O)-D stated they did not know the copy of the license should be included in the employee file. The licensee's undated policy titled, MN Statute 144A.479, Subd. 7 Personnel Records, indicated the employee record should contain evidence of professional licensure, registration, or certificate. The licensee lacked a personnel record policy specific to chapter 144G, which were the state statutes the licensee was providing care under. No other information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 660 SS=F	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: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included baseline testing and screening within the 90 days of hire for two of three employees (unlicensed personnel (ULP)-B, licensed assisted living director/owner (LALD/O)-D). 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).	0 660		

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	34952	A. BUILDING: _____ B. WING _____	05/17/2024

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0 660	Continued From page 23 ULP-B ULP-B was hired on November 11, 2022, to provided direct cares for the residents of the facility. ULP-B's employee record included a Baseline TB Screening Tool for Health dated March 1, 2024, and a document dated November 30, 2022, titled QuestQuanum T=SPOT.TB with a final result of negative. The employee record lacked the baseline TB screening tool within 90 days of hire. LALD/O-D LALD/O-D was hired on September 1, 2005, and performed duties as the licensed assisted living director, owner, and provided direct cares for the residents of the facility. LALD/O-D's employee record included a Baseline TB Screening Tool for Health dated March 2, 2024. The employee record lacked the baseline TB screening tool within 90 days of hire. On May 16, 2024, at 10:42 a.m., LALD/O-D stated they believed the TB screening should be performed yearly for each employee and should be completed at the date of hire. LALD/O-D stated it was missed for both employees. The licensee undated policy titled MN Statute 144G.42, Subd. 9 Tuberculosis Screening indicated each employee and volunteer having direct contact with residents should have a baseline health symptom screening prior to providing care to residents. No other information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	0 660		

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0 660	Continued From page 24 (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a written emergency preparedness plan (EPP) with all the required content as defined in Appendix Z. This had the potential to affect all residents, staff, and visitors.	0 680		

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0 680	Continued From page 25 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: The licensee's emergency disaster preparedness plan dated March 1, 2024, lacked evidence of the following required content: - risk assessment for the facility; - strategies for addressing facility and community-based risks (evacuation plans, staffing, surges/shortages, back-up plans); - emergency plan (EP) patient population; - process for EP collaboration with local, tribal, regional and State and Federal; - subsistence needs for staff and residents; - procedures for tracking of staff and patients; - policies and procedures including evacuation; - policies and procedures for sheltering; - policies and procedures for medical documents; - policies and procedures for volunteers; - arrangement with other facilities; - roles under a waiver declared by secretary; - emergency official contact information; - primary and alternative means for communication; - methods for sharing information; - sharing information on occupancy and needs; - long-term care (LTC) family notifications, and; - emergency preparation and testing requirements. On May 16, 2024, at 12:35 p.m., licensed	0 680		

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0 680	Continued From page 26 assisted living director/owner (LALD/O)-D stated they contacted the Lakeville Fire Chief, and they were not able to tell [licensee] the required content for the EPP. LALD/O-D stated they thought their EPP met the statutory requirements. The licensee's undated policy titled, MN Statute 144A.4791, Subd. 12 Emergency Management Policy, indicated [licensee] would have a plan in place to ensure the safety and well-being of the residents and employees during an emergency. The licensee lacked a policy specific to chapter 144G, which were the state statutes the licensee was providing care under. No other information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	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 receive training on the fire safety and evacuation	0 810		

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0 810	Continued From page 27 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 the interview and record review, the licensee failed to develop the fire safety and evacuation plan with the required content, failed to provide the required training, and failed to provide the required 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, 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 May 15, 2024, at 10:00 a.m., licensed	0 810		

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0 810	Continued From page 28 assisted living director (LALD)-D provided documentation on the fire safety and evacuation plan (FSEP), fire safety and evacuation training for the facility, and fire safety and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The FSEP did not include the facility-specific procedures for resident movement, evacuation or relocation during a fire or similar emergency. The facility Emergency Preparedness plan did include some provisions for the evacuation of residents but did not specify how to move or evacuate residents during a fire, including the identification of unique or unusual resident needs for evacuation. During the interview on May 15, 2024, at 10:30 a.m., LALD-D stated the focus of the FSEP was fire safety, and they had not been focused on the resident movement or evacuation in case of a fire or similar emergency. LALD-D confirmed that the FSEP to be updated with the facility-specific fire safety and the facility's building layout and environmental risks. TRAINING Record review of the available documentation indicated employees did not receive training twice per year after initial hire. During the interview on May 15, 2024, at 10:30 a.m., LALD-D stated the licensee provided annual training on the fire safety and evacuation plan to employees, but not twice per year after the initial hire, as required by statute. LALD-D confirmed there was no further documented training for the staff on the fire safety and evacuation plan as required by statute.	0 810		

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0 810	Continued From page 29 DRILLS Record review of the available documentation indicated that the licensee did conduct every other month but did not conduct evacuation drills twice per year per shift as required by statute. Provided documentation indicated that the provided drills were conducted for the day a shifty only, and the licensee failed to provide two drills for the night shift. During the interview on May 15, 2024, at 10:30 a.m., LALD-D verified that the licensee failed to provide two drills for the night shift, and no further drills were conducted besides those provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 820 SS=I	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee	0 820		

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0 820	Continued From page 30 failed to provide facilities that were not a distinct hazard to life. The licensee had lock hardware that required a key to exit the home on the egress side of the front door. This had the potential to affect all occupied residents, staff, and visitors because timely evacuation would not be possible in the event of a fire or other life-threatening emergencies. 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 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 May 15, 2024, at 10:00 a.m., survey staff toured the facility with the licensed assisted living director (LALD)-D. During the facility tour, it was observed that a key-only lock was installed on the front door. The front door was marked as an emergency egress exit on the posted evacuation plan, and an exit sign was posted over it. It was also observed the key-only lock was installed on the door to the exterior. During the interview on May 15, 2024, at 10:30 a.m., LALD-D stated that a resident sneaked out of the house and had to install the key locks to keep him inside. During the same interview, survey staff explained to LALD-D that the door with key-only lock constituted an obstruction of egress and a distinct hazard to life. LALD-D stated she understood the	0 820		

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0 820	Continued From page 31 deficiency. TIME PERIOD FOR CORRECTION: Two (2) days	0 820		
0 950 SS=F	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (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	0 950		

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0 950	Continued From page 32 by: Based on interview and record review, the licensee failed to include the required statutory language giving residents the right to identify a designated representative in writing in the contract and failed to provide the required verbatim notice on its own separate page for four of four residents (R1, R2, R3, and R4) with record review. 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 R1's Assisted Living Contract was signed on March 1, 2024. R2 R2's Assisted Living Contract was signed on April 3, 2024. R3 R3's Assisted Living Contract was signed on March 1, 2024. R4 R4's Assisted Living Contract was signed on March 1, 2024. The licensee's Assisted Living Contract form utilized for the above listed residents lacked the required verbatim "right to designate a	0 950		

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0 950	Continued From page 33 representative for certain purposes" notice on a document separate from the contract. On May 17, 2024, at 8:18 a.m., licensed assisted living director/owner (LALD/O)-D stated they were not aware of the requirement to include "right to designate a representative for certain purposes" notice in the assisted living contract and on a document separate from the contract. LALD/O-D also stated the same Assisted living contract form was used for all residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 950		
01290 SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	01290		

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01290	Continued From page 34 review, the licensee failed to ensure a background study (BGS) was submitted and received in affiliation with the assisted living licensee for one of nine employees (unlicensed personnel (ULP)-B). This had the potential to affect all residents living in the assisted living facility. This resulted in an immediate correction order on May 14, 2024. 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 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: ULP- B ULP- B was hired on November 6, 2022, to provide direct cares and services to residents. The licensee's employee schedule from May 13-26, 2024, indicated ULP-B was scheduled to work day shifts (7 a.m. to 7 p.m.) on May 13 and 20, and night shifts (7 p.m. to 7 a.m.) on May 17, 18. On May 13, 2024, ULP-B was observed caring for residents throughout the day. ULP-B's employee record lacked evidence indicating ULP-B's background study was submitted for the licensee's health facility identification (HFID) 34952. The licensee's NETStudy 2.0 did not include	01290		

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01290	Continued From page 35 ULP-B in the list of employees whose BGS was affiliated to the licensee's HFID 34952. A Background Study Notice letter from Department of Human Services (DHS) regarding ULP-B's BGS application submitted for the licensee's sister facility under HFID 27193 dated February 21, 2024, read, "background study fingerprints and photo were not provided in the time required- the entity must immediately remove you from your position." A screenshot taken from department of human services NETStudy 2.0 website on May 14, 2024, at 9:21 a.m., indicated ULP-B was separated from HFID 27193 on January 19, 2024, and supervision was required. On May 14, 2024, at 9:41 a.m., licensed assisted living director/owner (LALD/O)-D stated they were responsible for checking background studies and their email and address was listed as an authorized person to run background studies. LALD/O-D stated they did not initiate a BGS for the licensee's HFID 34952. On May 14, 2024, at 10:00 a.m., the surveyor showed LALD/O-D the above-mentioned letter from DHS and inquired if they had received it. LALD/O-D stated they had not received any letter, and they had paid for fingerprinting. On May 14, 2024, at 10:05 a.m., LALD/O-D called ULP-B on the phone to ask when they completed the fingerprinting. ULP-B stated they received a letter dated February 21, 2024, from DHS and read the letter, "background study fingerprints and photo were not provided in the time required- the entity must immediately remove you from your position." The surveyor	01290		

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01290	Continued From page 36 inquired whether ULP-B had informed LALD/O- D about the letter. ULP-B stated, "No" they had not spoken with LALD/O-D about the letter, but they asked LALD/O-D if their BGS was cleared and LALD/O-D told them everything was cleared. The surveyor inquired why ULP-B continued to work without informing the licensee when the letter read they should be removed from their position immediately. ULP-B stated, "I did not think this [referring to the letter from DHS] mean anything, I usually get a junk mail too." On May 14, 2024, at approximately 11:40 a.m., LALD/O-D stated ULP-B had been providing direct cares and service to the licensee's residents without supervision. The licensee's undated, Background Studies Policy read, "1. Each facility employee/volunteer or contractor who will provide direct care to residents must have a background study completed. The forms will be completed at the time of hire. If the person fails to provide the information necessary to complete the background study, their application for direct care employment will not be completed. 2. Employees may not work until the results of the background study have been received. (The law allows an individual to provide direct contact services while a study is pending IF that person is under continuous direct supervision of the employer) 3. If a prospective employee is denied employment or an existing employee is removed from a position, information may be submitted by the person to the Facility as verification of an inaccurate criminal record or that the person has completed the rehabilitation process. An existing employee shall be removed from direct resident service pending a determination."	01290		

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	34952	A. BUILDING: _____ B. WING _____	05/17/2024

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01290	Continued From page 37 No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE	01290		
01370 SS=F	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy;	01370		

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01370	Continued From page 38 (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and competency evaluations were completed for all required skill areas, prior to providing services, for two of three employees (unlicensed personnel (ULP)-B, licensed assisted living director/owner (LALD/O)-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-B ULP-B was hired on November 11, 2022, to provide direct cares for the residents of the facility. On May 13, 2024, the surveyor observed ULP-B caring for residents throughout the day. ULP-B's employee record lacked evidence of the following training: -preparation of modified diets as ordered by a	01370		

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01370	Continued From page 39 licensed health professional, and; -awareness of commonly used health technology equipment. LALD/O-D LALD/O-D was hired on September 1, 2005, to perform duties as the licensed assisted living director, owner of the facility, and to provide direct cares for the residents of the facility. LALD/O-D was not a licensed nurse. LALD/O-D's employee record lacked evidence of the following training: -documentation for all services provided; -reports of changes in resident's condition to the supervisor designated by the assisted living provider; -basic infection control, including blood-borne pathogens; -training on the prevention of falls for providers working with the elderly or individuals at risk of falls; -medication, exercise and treatment reminders; -awareness of commonly used health technology. Although LALD/O-D was a licensed health professional under the Board of Executives for Long Term Services and Supports, Minnesota Rule Chapter 6400 indicated the course requirements, basic areas of study, and field experience for licensed assisted living directors pertained to customer care, human resources, finance, environment, management and leadership, person-centered care practices, vulnerable adult protection, Minnesota rules governing compliance, landlord-tenant law, role of the state ombudsman, elder care rights, practice acts for Minnesota health-related licensing boards, client and family relationships, and health and wellness topics. The course requirements did	01370		

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01370	Continued From page 40 not include the above-mentioned missing training topics related to direct care. On May 16, 2024, 9:46 a.m., the surveyor called ULP-B and left a voicemail requesting a call back. On May 16, 2024, at 9:50 a.m., clinical nurse supervisor (CNS)-C stated they observed staff performing cares for residents and completed documentation as evidence staff members were competent in providing care. CNS-C stated they used a template for the different areas of care provided to residents. On May 16, 2024, at 10:34 a.m., LALD/O-D stated when staff are hired, [licensee] trained staff using Educare (software training program), and the CNS observed staff members perform care and completed documentation as evidence staff were competent in providing care. LALD/O-D stated they were aware of the required documentation, and "forgot" to complete the required paperwork. On May 16, 2024, at 11:25 a.m., Minnesota Department of Health (MDH) concluded the survey, but the surveyor had not received a return telephone call from ULP-B. On June 4, 2024, at 10:55 a.m., a representative from the Minnesota Board of Executives for Long-Term Services and Supports stated the medication management training requirements for LALDs is a broad overview pertaining to medication awareness, and the course requirements for LALDs does not include any nurse-delegated training nor competency checks. The licensee's undated policy titled MN Statutes 144G.60 Subd. 2,3,4 Qualifications, Training and	01370		

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01370	Continued From page 41 Competency indicated [licensee] would provide training to all staff providing and supervising assisted living services at the time of hire to meet state guidelines and quality standards. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		
01380 SS=F	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and competency evaluations were completed for all required skill areas, prior to providing services, for two of three employees (unlicensed personnel (ULP)-B, living assisted licensed director/owner	01380		

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01380	Continued From page 42 (LALD/O)-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-B ULP-B was hired on November 11, 2022, to provide direct cares for the residents of the facility. On May 13, 2024, the surveyor observed ULP-B caring for residents throughout the day. ULP-B's employee record lacked documentation of signed training and competencies by the registered nurse for: Training: -observation, reporting, and documenting of resident status; -basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; and -recognizing physical, emotional, cognitive, and developmental needs of the resident. Competency evaluations: -reading and recording temperature, pulse, and respirations of the resident; -safe transfer techniques and ambulation, and; -range of motioning and positioning. LALD/O-D	01380		

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01380	Continued From page 43 LALD/O-D was hired on September 1, 2005, to perform duties as the licensed assisted living director, owner of the facility and provide direct cares for the residents of the facility. LALD/O-D was not a licensed nurse. LALD/O-D's employee record lacked documentation of signed training and competencies by the registered nurse for: Training: -basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; and -recognizing physical, emotional, cognitive, and developmental needs of the resident. Competency evaluations: -reading and recording temperature, pulse, and respirations of the resident; and -safe transfer techniques and ambulation. Although LALD/O-D was a licensed health professional under the Board of Executives for Long Term Services and Supports, Minnesota Rule Chapter 6400 indicated the course requirements, basic areas of study, and field experience for licensed assisted living directors pertained to customer care, human resources, finance, environment, management and leadership, person-centered care practices, vulnerable adult protection, Minnesota rules governing compliance, landlord-tenant law, role of the state ombudsman, elder care rights, practice acts for Minnesota health-related licensing boards, client and family relationships, and health and wellness topics. The course requirements did not include the above-mentioned missing training topics related to direct care.	01380		

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01380	Continued From page 44 On May 16, 2024, 9:46 a.m., the surveyor called ULP-B and left a voicemail requesting a call back. On May 16, 2024, at 9:50 a.m., clinical nurse supervisor (CNS)-C stated they observed staff performing cares for residents and completed documentation as evidence staff members were competent in providing care. CNS-C stated they used a template for the different areas of care provided to residents. On May 16, 2024, at 10:34 a.m., LALD/O-D stated when staff are hired, [licensee] trained staff using Educare (software training program), and the CNS observed staff members perform care and completed documentation as evidence staff were competent in providing care. LALD/O-D stated they were aware of the required documentation, and "forgot" to complete the required paperwork. On May 16, 2024, at 11:25 a.m., Minnesota Department of Health (MDH) concluded the survey, but the surveyor had not received a return telephone call from ULP-B. On June 4, 2024, at 10:55 a.m., a representative from the Minnesota Board of Executives for Long-Term Services and Supports stated the medication management training requirements for LALDs is a broad overview pertaining to medication awareness, and the course requirements for LALDs does not include any nurse-delegated training nor competency checks. The licensee's undated policy titled MN Statutes 144G.60 Subd. 2,3,4 Qualifications, Training and Competency indicated [licensee] would provide training to all staff providing and supervising assisted living services at the time of hire to meet	01380		

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01380	Continued From page 45 state guidelines and quality standards. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380		
01470 SS=D	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff 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 46 (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 interview and record review, the licensee failed to ensure staff providing services completed an orientation to assisted living facility licensing requirements and regulations before providing services for one of three employees (unlicensed personnel (ULP)-B). 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	01470		

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01470	Continued From page 47 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-B was hired on November 11, 2022, to provide direct cares for the residents of the facility. ULP-B's employee record lacked evidence of orientation to assisted living regulations (Minnesota Statutes, chapter 144G.63, subdivision 2) effective August 1, 2021, for the following: -Overview of Assisted Living statutes; -Review of provider's policies and procedures; -Reporting maltreatment of vulnerable adults or minors; -Handing of resident complaints, reporting of complaints, where to report; -Consumer advocacy services; -Review of types of Assisted Living services the employee will provide and provider's scope of license; and -Principles of person-centered planning/service delivery. On May 16, 2024, at 10:44 a.m., LALD/O-D stated orientation training should be before employees start providing cares, and Educare (software training program) is used for the orientation training. LALD/O-D stated they were confused with the Statutory requirements. The licensee's undated MN Statute 144g.63 Subd. 1 and 2 Facility Employee Orientation indicated staff who provide direct care, supervisor or management services of the facility are required to complete orientation topics required	01470		

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01470	Continued From page 48 by the Minnesota Statutes and rules for assisted living. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
01620 SS=G	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the	01620		

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01620	Continued From page 49 licensee failed to ensure the registered nurse (RN) accurately assessed a resident who had demonstrated the inability to maintain his own safety and who the licensee had determined was unable to safely leave the facility without an escort. Additionally, the licensee failed to implement appropriate safety interventions after two occurrences of the resident leaving the facility without an escort. 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: R4 was admitted to the licensee on April 13, 2022, and began receiving assisted living services. R4's diagnoses included acute toxic metabolic encephalopathy, acute alcohol withdrawal, alcohol use disorder, cirrhosis, coagulopathy, thrombocytopenia, anemia, hypokalemia, hypomagnesemia, hypophosphatemia, diabetes type two. R4's undated service plan form, indicated R4 received services for bathing, dining, grooming, medication administration, toileting, skin care, positioning, and transferring. The service plan contained no information about R4's safety needs or inability to leave the facility without an escort.	01620		

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01620	Continued From page 50 R4's most recent Service Plan Re-assessment and Monitoring - 90-day nursing Reassessment of service plan dated May 2, 2024, indicated resident is alert and oriented to person and place. The assessment contained no information about R4's safety needs or inability to leave the facility without an escort. R4's Evaluation and Management (completed by a medical provider) dated October 17, 2023, indicated R4's past medical history included: alcoholic hepatitis, dementia associated with alcoholism anemia; gastro-esophageal reflux disease; and hypertension. The Document also indicated, "Alcohol use, unspecified with alcohol-induced persisting dementia. Pt [patient] wondering why he has to live in the ALF [assisted living facility]. States he is able to take care of himself and wants to live with his friend. Does not seem to understand that he needs nursing services. Also staff reports memory impairment [sic] frequently needs reminders that he has eaten." R4's handwritten progress note by unlicensed personnel (ULP)-B dated September 4, 2023, indicated staff could not find R4 in his room as they were getting ready to serve supper. ULP-B then called licensed assisted living director/owner (LALD/O)-D and reported R4 was missing. LALD/O-D searched for R4 but was unable to find R4. LALD/O-D called police and reported the resident was missing. Progress note did not provide any further information. R4's handwritten progress note by ULP-B dated December 12, 2023, indicated R4 left the facility at 11:15 a.m.; ULP-B reported it to LALD/O-D. LALD/O reported to police R4 was missing and clinical nurse supervisor (CNS)-C conducted an	01620		

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01620	Continued From page 51 out of the facility search along with LALD/O-D. Resident was found at a bar in Lakeville, approximately 0.5 miles away, and brought back to the facility by police at around 1:30 p.m., on December 12, 2023. R4's facility Nursing Notes from January 5, 2023, to April 21, 2024, which contained typed notes pertaining to R4, signed by CNS-C, did not mention any of the above listed missing resident incidents for R4. R4's Service Plan Re-assessment and Monitoring- 90-day nursing Reassessment of service plan completed on November 2, 2023, 59 days after the first missing resident note did not address the missing resident incident of September 4, 2023. The re-assessment indicated resident is alert and oriented to person and place. The form included a behavior section and indicated under "Behavior- describe behavior/behavior changes", "Resident has been doing well, does not offer any complaints for writer and is pleasant during exchange. Staff report resident occasionally becoming verbally abusive towards staff. Refuses skin assessment, denies any skin concerns." The assessment contained no information about R4's safety needs or inability to leave the facility without an escort. R4's Service Plan Re-assessment and Monitoring- 90-day nursing Reassessment of service plan completed on February 2, 2024, 51 days after the second missing resident note did not address the missing resident incident of December 12, 2023. The re-assessment indicated resident is alert and oriented to person and place. The form included a behavior section and indicated under "Behavior- describe behavior/behavior changes section", "Resident	01620		

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01620	Continued From page 52 has been doing well, does not offer any complaints for writer and is pleasant during exchange. Staff report resident occasionally becoming verbally abusive towards staff. Refuses skin assessment, denies any skin concerns." The assessment contained no information about R4's safety needs or inability to leave the facility without an escort. R4's most recent Individual Abuse Prevention Plan (IAPP) dated March 1, 2024, under "Other Notes" indicated, "[R4] often times will try to leave the home, but staff are constantly watching and monitoring [R4]. The IAPP contained no information about R4's safety needs or inability to leave the facility without an escort. R4's most recent Service Plan Re-assessment and Monitoring- 90-day nursing Reassessment" of service plan dated May 2, 2024, indicated resident is alert and oriented to person and place. The assessment contained no information about R4's safety needs or inability to leave the facility without an escort. On May 15, 2024, at 10:00 a.m., survey engineer toured the facility with the LALD/O-D. During the facility tour, it was observed that a key-only lock was installed on the front door. The front door was marked as an emergency egress exit on the posted evacuation plan, and an exit sign was posted over it. It was also observed the key-only lock was installed on the door to the exterior. On May 15, 2024, at 10:30 a.m., during survey engineer interview with LALD/O-D, LALD/O-D stated a resident sneaked out of the house and they had to install the key locks to keep resident inside. LALD/O-D also stated the door with key-only lock constituted an obstruction of egress	01620		

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01620	Continued From page 53 and a distinct hazard to life. LALD/O-D stated they understood the deficiency. On May 15, 2024, at 11:30 a.m., CNS-C stated R4 "sneaks out" and that is why they put the locks on the doors. CNS-C stated R4 is confused but not at the level of dementia, he does not remember who his guardian is, even though R4 met the guardian a few times. On May 15, 2024, at 11:50 a.m., surveyor asked why the licensee put locks on the doors if R4 was not confused at a dementia level, and also asked if putting a lock on the door was infringing upon R4's and other resident's rights to come and go as they please. CNS-C stated R4's level of confusion was not that much but he does not remember who his guardian was and may think he belongs to another house in the neighborhood if he got out. Surveyor inquired to know how they are planning to keep R4 safe now after removing locks from all doors to comply with fire code. CNS-C stated, "We will just keep an eye on him, that is the challenge; I guess they could put a door chime where it rings." On May 15, 2024, at 12:13 p.m., ULP-B stated regarding the incident of December 12, 2023, they could not see R4 in the house, so they called LALD/O-D. ULP-B also stated CNS-B was at the facility during the time. Surveyor asked where R4 went and where was he found. ULP-B stated R4 was found outside and pointed to the facility backyard through the kitchen window for the surveyor to see (even though ULP-B documented in a progress note on December 12, 2023, that R4 was found at a bar in Lakeville). CNS-B stated they were not at the facility at the time of incident and was not aware of the situation. Surveyor showed the above-mentioned handwritten	01620		

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01620	Continued From page 54 progress note, dated December 12, 2023, to CNS-B and asked if they had seen the note. CNS-B stated no they had not seen the note and stated they do not review the notes, the notes were only for ULP-to-ULP communication purposes. On May 15, 2024, at 12:55 p.m., CNS-B changed their statement and stated they did receive a call from ULP-B about the missing resident incident of December 12, 2023, and stated they were aware of the incident. On May 15, 2024, at 1:15 p.m., surveyor asked if there were any nursing interventions put in place and any change of condition assessments completed after the above-mentioned incidents. CNS-B stated there were no assessments or IAPP completed, their intervention for the first incident was to keep an eye on the resident and the for the second incident owners decided to put locks on the door. On May 15, 2024, 1:38 p.m., LALD/O-D stated they reported both incidents to the Minnesota Adult Abuse Reporting Center (MAARC) the next day, reported to police, and R4's guardian. LALD/O-D stated their first intervention was to keep an eye on the resident, second was to put locks on the door. LALD/O-D also stated at the time they did not think putting locks on the doors was infringing resident rights or a violation of fire code. On May 16, 2024, at 10:47 a.m., LALD/O-D stated there were no incident reports completed for the missing resident incidents. On May 16, 2024, 1:25 p.m., surveyor inquired to know more about the missing resident incident of	01620		

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01620	Continued From page 55 September 4, 2023. LALD/O-D stated resident took a taxi and went to a bank in Minneapolis approximately 24 miles away when he left the facility in September. Guardian notified the bank to call police if they saw R4 before guardian made it to the bank. Police were notified by the bank when R4 showed up at the bank. Police attended to R4 at the bank and called LALD/O-D to go get R4. LALD/O-D drove to Minneapolis to bring R4 back to the facility. LALD/O-D stated R4 was drunk, R4 got in the car but he opened the door and got out at a stop light. LALD/O-D called police. R4 was then picked up by ambulance and brought to the hospital, stayed in the hospital for few hours, and was brought back to the facility on the same day via ambulance. On May 15, 2024, at 1:10 p.m., the surveyor placed a call to R4's guardian, but as of 2:30 p.m., May 16, 2024, did not receive a call back. On May 16, 2024, 3:05 p.m., surveyor inquired how the licensee decided R4 cannot leave the facility unescorted and how they decided to call police when R4 went missing. Surveyor also asked if they would do the same for other residents. LALD/O-D stated they would not do the same for other residents but R4 gets confused, R4 would go out and get drunk and may forget where they are. They stated they do not have any order from the doctor or court to escort R4, but it is not safe for R4 to leave unescorted, and they did not want to be held responsible if something bad happened to R4. LALD/O-D also stated they would not let R4 go unescorted, and the service plan has to change to show R4 needs escort. The licensee's undated missing resident policy indicated, "d. The RN/designee notifies police, search teams, Common Entry Point, etc. when	01620		

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01620	Continued From page 56 the resident has been located. e. The RN completes and files an incident report and documents the incident in the resident's record. f. The RN updates the resident's assessment and service plan as needed and orients staff to any new interventions or procedures to reduce the risk of future problems, such as unescorted wandering, for this or other residents. g. The RN works with the resident's representative in identifying and implementing any additional safety procedures, alarms, or devices to reduce the risk of future unplanned departures of residents. h. The RN contacts the resident's case manager (if applicable). No further information was provided. TIME PERIOD FOR CORRECTION: Immediate In addition, based on observation, interview, and record review the licensee failed to assess and monitor a wound on the buttock for one of one resident (R3). The licensee also failed to use the uniform assessment tool with all the required content for five of five residents (R1, R2, R3, R4, and R5). The findings include: R3 was admitted on October 14, 2022, and began receiving assisted living services. R3's diagnoses included acquired absence of the right leg below the knee, morbid obesity, hypertension, and diabetes mellitus. R3's Service Plan dated October 5, 2022, indicated R3 received services for, bathing,	01620		

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01620	Continued From page 57 dining, grooming, medication administration, toileting, skin care, and transferring. WOUND ASSESSMENT On May 17, 2024, at 9:00 a.m., the surveyor observed wound/skin care performed by LALD/O-D on R3's buttock and left leg. Surveyor observed a reddened area on the left buttock with small open wound with no dressing to cover the wound. Surveyor also observed a catheter for urine and brief for bowel incontinence. R3's left leg had flaky skin with no open area. LALD/O-D verified an open wound on the left buttock and stated the wound was bleeding. R3's medical record included a most recent assessment form entitled Service Plan Reassessment and Monitoring- 30 Day Reassessment of Service Plan dated May 2, 2024, and indicated R3's skin condition was not intact. The assessment lacked evidence that the buttock wound was assessed and monitored. The assessment also lacked evidence of appropriate nursing or medical intervention put in place for treating the buttock wound. CONTENTS OF UNIFORM ASSESSMENT TOOL R3's 90-day assessment form entitled Service Plan Reassessment and Monitoring- 30 Day Reassessment of Service Plan dated May 2, 2024, lacked the following areas required on the uniform assessment tool per Minnesota Rules Chapter 4659.0150: A) the resident's personal lifestyle preferences; (1) sleep schedule, dietary and social needs, leisure activities, and any other customary routine that is important to the resident's quality of life; (2) spiritual and cultural preferences; and (3) advance health care directives and	01620		

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01620	Continued From page 58 end-of-life preferences, including whether a person has or wants to seek a "do not resuscitate" order and "do not attempt resuscitation order" or "physician/provider orders for life-sustaining treatment" order; B) activities of daily living; (1) toileting pattern, bowel, and bladder control; (2) dressing, grooming, bathing, and personal hygiene; (3) mobility, including ambulation, transfers, and assistive devices; and (4) dental status, oral care, and assistive devices and dentures, if applicable; C. instrumental activities of daily living, including: (1) ability to self manage medications; (2) housework and laundry; and (3) transportation; D. physical health status, including: (1) a review of relevant health history and current health conditions, including medical and nursing diagnoses; (2) infectious conditions; (3) a review of medications according to Minnesota Statutes, section 144G.71, subdivision 2, including prescriptions, over-the-counter medications, and supplements, and for each: (a) the reason taken; (b) any side effects, contraindications, allergic or adverse reactions, and actions to address these issues; (c) the dosage; (d) the frequency of use; (e) the route administered or taken; (f) any difficulties the resident faces in taking the medication; (g) whether the resident self administers the medication; (h) the resident's preferences in how to take medication;	01620		

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01620	Continued From page 59 (i) interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications; and (j) provide instructions to the resident and resident's legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications; (4) a review of medical, dental, and emergency room visits in the past 12 months, including visits to a primary health care provider, hospitalizations, surgeries, and care from a postacute care facility; (5) a review of any reports from a physical therapist, occupational therapist, speech therapist, or cognitive evaluations within the last 12 months; and (7) weight E. communication and sensory capabilities, including: (1) hearing; (2) vision; (3) speech; (4) assistive communication and sensory devices including hearing aids; and (5) the ability to understand and be understood; F. pain, including: (1) location, frequency, intensity, and duration; and (2) effectiveness of medication and nonmedication alternatives; G. skin conditions; H. nutritional and hydration status and preferences; I. list of treatments, including type, frequency, and level of assistance needed; J. nursing needs, including potential to receive nursing-delegated services;	01620		

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01620	Continued From page 60 K. risk indicators, including: (1) history of falls; (2) emergency evacuation ability; (3) complex medication regimen; (4) risk for dehydration, including history of urinary tract infections and current fluid intake pattern; (5) risk for emotional or psychological distress due to personal losses; (6) unsuccessful prior placements; (7) elopement risk including history or previous elopements; (8) smoking, including the ability to smoke without causing burns or injury to the resident or others or damage to property; and (9) alcohol and drug use, including the resident's alcohol use or drug use not prescribed by a physician; L. who has decision-making authority for the resident, including: (1) the presence of any advance health care directive or other legal document that establishes a substitute decision maker; and (2) the scope of decision-making authority of a substitute decision maker under subitem (1); and M. the need for follow-up referrals for additional medical or cognitive care by health professionals. On May 15, 2024, at approximately 10:00 a.m., CNS-C stated they use the same assessment tool they used for R3, for all of the licensee's residents. On May 17, 2024, at approximately 9:15 a.m., LALD/O-D stated they notify CNS-C every time they see change on R3's wound. LALD/O-D stated the last time they notified CNS-C about the wound was last week.	01620		

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01620	Continued From page 61 On May 17, 2024, at approximately 9:45 a.m., CNS-C stated the last time they saw R3's buttock wound was last week. CNS-C stated they did not make changes to the wound treatment order, did not notify providers, and did not complete change of condition assessments. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
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,	01790		

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01790	Continued From page 62 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: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) documented training and/or competencies for one of one unlicensed personnel ((ULP)-A)	01790		

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01790	Continued From page 63 who would provide medications for residents with unplanned time away from home when a licensed nurse was not available. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-A was hired on June 11, 2021, to provide direct services to residents. ULP-A's employee record lacked evidence of training and competency in preparing medications for unplanned times away when the licensed nurse is not available. On May 15, 2024, at 12:15 p.m., ULP-A stated they did put medication in a little bag and gave it to residents when residents had to go on a leave of absence unexpectedly. On May 17, 2024, at approximately 11:10 a.m., clinical nurse supervisor (CNS-C) stated ULPs did prepare medications for a resident who was going on unplanned times away. CNS-C stated ULPs did not receive a specific training on preparing medications for unplanned times away and there was no specific instruction written by the RN for unplanned times away medication preparation. The licensee's undated Medications for a	01790		

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01790	Continued From page 64 Resident Who will be Away from Facility When Medications are Scheduled Policy read, " 5. For unplanned time away when the nurse is not available, the RN may delegate this task to the unlicensed personnel if: a. The registered nurse has trained the unlicensed staff and determined the unlicensed staff competent to follow the procedures for giving medications to residents. b. The registered nurse has developed written procedures for the unlicensed staff, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures will address: i. The type of container to be used for the medications appropriate to the facility's medication system ii. How the container must be labeled iii. Written information about the medications to be provided iv. How the unlicensed staff must document in the resident's record what medications have been provided, including the date the medications were provided and who received them, the person who provided the medications to the resident, the number of medications provided to the resident and other required information v. How the registered nurse will 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 their designee vi. A review by the registered nurse of the completion of the task and to verify that it was done accurately by the unlicensed staff 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 medications and doses of the returned medications."	01790		

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01790	Continued From page 65 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01790		
01820 SS=E	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to maintain current medication orders for two of three residents (R2, R3) with 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 a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R2 R2's diagnoses included diabetes mellitus, personality disorder, morbid obesity, anxiety disorder severe persistent asthma, agitation, depressive disorder, and overactive bladder.	01820		

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01820	Continued From page 66 R2's Service Plan dated April 3, 2024, indicated R2 received services for, bathing, dining, grooming, medication administration, toileting, skin care, and transferring. R2's medication administration record (MAR) dated May 1, 2024, through May 31, 2024, indicated R2 received the following medications: aripiprazole tablet (Tab) 10 milligram (mg) levothyroxine 112 microgram (mcg), folic acid 1mg tab, Metamucil 1 packet, guaifenesin 600mg tab extended release (ER), furosemide 20mg tab, nystatin powder 60 Gram (Gm), olopatadine drop 0.1%, senexon-s tab 8.6-50mg, ferrous sulfate 325g, melatonin 3mg tab, banophen 25mg tab, eliquis 5mg tab, Gavilax powder 17gm, gabapentin tab 600mg, lantus solostar 100unit/milliliter (ml) pen, chlorohexidine 0.12 % solution 15ml, metformin 1000mg tab, vitamin C 500mg tab, lorazepam 1mg tab, rosuvastatin 10mg tab, Victoza injection 1.8 mg, insulin lispro Kwik pen 100u/ml, metoprolol succinate 100mtab ER, pantoprazole 20mg tab, refresh plus 0.5% ophthalmic drop, sertraline 100mg tab, Spiriva Respimat 125mg/accentuate (ACT) 2 puffs. R3 R3's diagnoses included acquired absence of the right leg below the knee, morbid obesity, hypertension, and diabetes mellitus. R3's Service Plan dated October 5, 2022, indicated R3 received services for, bathing, dining, grooming, medication administration, toileting, skin care, and transferring. R3's MAR dated May 1, 2024, through May 31, 2024, indicated R3 received the following medications: aspirin 81mg enteric coated,	01820		

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01820	Continued From page 67 losartan 100mg tab, vitamin D3 125mcg tab, NovoLog flex pen 100u/ml, ibuprofen 800mg as needed (PRN), Tylenol 500mg tab PRN, oxycodone HCL 5mg tab PRN, refresh ophthalmic solution, metformin 100mg tab, ferrous sulfate 324mg tab, ketoconazole Cream 2%, vitamin C 500mg tab, rosuvastatin 5mg tab, calmoseptine ointment topical. On May 1, 2024, at approximately 9:55 a.m., clinical nurse supervisor (CNS)-C stated they were not able to produce documentation of current written or electronically recorded prescription with the practitioner's manual or electronic signature for any prescribed medications managed by the licensee. CNS-C also stated they did not have any signed orders for any of the licensee's resident except for R1. The licensee's undated Medication Management Services policy read, "4. Medication Management Policies and Procedures. The RN will develop and update as needed specific procedures for the following medication management activities: a. Requesting and receiving prescriptions for current and changing medications b. Implementing new prescriptions and updating the resident's medication record and medication management plan, when necessary c. Training and determining competency of staff who will provide medication administration or other medication management services d. Documentation of communications with the prescriber, pharmacist, resident, and resident's representative, if any, and education of residents about their medications e. Documentation of medication set up f. Preparation and administration of medications and documentation of these activities	01820		

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01820	Continued From page 68 g. Controlling and storing medications including controlled substances h. Medication errors i. Monitoring and evaluating medication use and reassessing resident's medication management services, including signs and symptoms of side effects, allergic reactions, or dose intolerance j. Verifying that prescription drugs are administered as prescribed k. Disposal of medications, including controlled substances when no longer needed." No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to ensure all medications were securely locked in substantially constructed compartments and permitted only authorized personnel to have access for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	01880		

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01880	Continued From page 69 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: The facility was a two-level rambler style home with a main floor and a basement. There was a black child safety gate installed on top of the stairs on the main level. The safety gate opened and closed by maneuvering the lever without keys or locks to gain access to the basement. R2's Service Plan dated April 3, 2024, indicated R2 received services for, bathing, dining, grooming, medication administration, toileting, skin care, and transferring. On May 13, 2024, at 11:22 a.m., the surveyor observed nystatin powder 100,000 units (u) per gram (g) topical medication, olopatadine drop 0.1% ophthalmic medication, chlorohexidine gluconate oral rinse United States pharmacopeia (usp), 0.12%, and unlabeled tums ultra strength 1000 (milligram)mg, unlocked and unsecured, placed on top of a bed side table in R2's bedroom. On May 13, 2024, at 11:25 a.m., the surveyor observed a small size refrigerator located in the basement. Surveyor observed the refrigerator was locked by a white child safety strap lock. The strap lock has a slide to open button for adults to gain access without keys. The surveyor also observed the following medications for R2 stored within: - Lantus solar 100unit/ milliliter (ML) pen; - Victoza 18 milligram (mg)/3ML injectable pen; and	01880		

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01880	Continued From page 70 - Insulin lispro kwikpen 100unit/ML. On May 13, 2024, at 11:27 a.m., the surveyor observed residents' medication stored in unlocked wall cabinets in the basement. The cabinets contained various medication in plastic medicine pill bottles, stored in separate clear plastic storage boxes for storing each resident's extra pills. There was no locking mechanism on the cabinet doors. On May 14, 2024, at 8:09 a.m., the surveyor observed a white Dreambaby adhesive magnetic lock with the key fob for the lock placed out in the open on the side of the refrigerator in the kitchen. Unlicensed personal (ULP)-A grabbed they key fob and opened the medicine cabinet located in the kitchen by using the key fob. There was a wooden narcotic box in the medicine cabinet locked with padlocks. Surveyor also observed a single key right next to the narcotic box. ULP-A verified the key was to open the padlock on the narcotic box. On May 14, 2024, at 8:20 a.m., the surveyor observed medication administration performed by ULP-A. ULP-A prepared R3's medication and locked the medicine cabinet and put the key fob in the kitchen drawer where they put utensils. The drawer was unlocked and unsecured with no locking mechanism. Any resident who had access to the kitchen could gain access to the drawer and the key fob. On May 14, 2024, at 8:43 a.m., the surveyor observed R4 walking with their walker to the kitchen. On May 15, 2024, at 11:49 a.m., the surveyor observed olopatadine drop 0.1% ophthalmic	01880		

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01880	Continued From page 71 medication, and chlorohexidine gluconate oral rinse usp, 0.12%, unlocked and unsecured placed on top of a bed side table in R2's bedroom. On May 15, 2024, at 11:28 a.m., clinical nurse supervisor (CNS-C) stated none of their residents go to the basement, that was why they did not put locks on the cabinets or the refrigerator. CNS-C also verified the basement was not secured for storing medication in unlocked cabinets or refrigerator. On May 15, 2024, at approximately 11:40 a.m., CNS-C stated "we usually keep it (key fob) on the side of the refrigerator, that is where we like it to be and, in the drawer, sometimes they (referring to ULPs) carry it in their pockets. Surveyor explained their observation of R4 walking into the kitchen on May 14 and their observation of the narcotic box padlock key, which was right by the narcotic box and inquired if putting the key fob to the medicine cabinet on the side of the refrigerator or in the kitchen drawer with no locking mechanism would be safe. CNS-C stated, "we do trust [R4]. I do not know if [R4] would know what the key fob is for." CNS-C also stated none of their residents were able to self-administer medication. R2's medications were supposed to be in a locked cabinet, and R2 did not have an order for tums and CNS-C stated they were not aware R2 had tums in their room. The licensee's 7.11 undated Medication Management Services policy read, "1. Determination of Scope of Medication Management Services. The Assisted Living Director and Nursing Supervisor will determine the scope of medication management services the facility will offer, which may include:	01880		

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01880	Continued From page 72 a. Medication set-ups b. Administration of medications c. Storing and securing medications d. Documenting medication activities e. Verifying and monitoring effectiveness of systems to ensure safe handling and administration f. Coordinating refills g. Handling and implementing changes to prescriptions h. Communicating with the pharmacy about the resident's medications i. Coordinating and communicating with the prescriber; and j. Communicating with the resident, their representative and, when appropriate, the resident's family. medications will be kept securely locked and stored per manufacturer's directions and only authorized staff will have access to stored medications." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	01890		

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01890	Continued From page 73 review, the licensee failed to ensure time sensitive medications were labeled with the date opened for one of five residents (R2) and failed to discard expired medication for one of five 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 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: NO OPENED-ON DATE R2 R2's diagnoses included diabetes mellitus, personality disorder, morbid obesity, anxiety disorder severe persistent asthma, agitation, depressive disorder, and overactive bladder. R2's Service Plan dated April 3, 2024, indicated R2 received services for, bathing, dining, grooming, medication administration, toileting, skin care, and transferring. On May 17, 2024, at 10:13 a.m., the surveyor observed the medication cabinet and observed the following time sensitive medication was opened without opened on date label: - R2's Lantus solar 100unit/ milliliter (ML) pen; - R2's Victoza 18 milligram (mg)/3ML injectable pen; and - R2's insulin lispro kwikpen 100unit/ML.	01890		

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01890	Continued From page 74 EXPIRED MEDICATION R3 R3's diagnoses included acquired absence of the right leg below the knee, morbid obesity, hypertension, and diabetes mellitus. R3's Service Plan dated October 5, 2022, indicated R3 received services for, bathing, dining, grooming, medication administration, toileting, skin care, and transferring. On May 17, 2024, at 9:00 a.m., the surveyor observed licensed assisted living director/owner (LALD/O)-D apply ketoconazole cream, in between R3's left toes. On May 17, 2024, at 10:21 a.m., the surveyor observed R3's ketoconazole cream, which was expired on November 29, 2023, in the medication cabinet. On May 17, 2024, at 10:21 a.m., clinical nurse supervisor (CNS-C) verified the expired ketoconazole cream was applied to R3 by LALD/O-D during the 9:00 a.m., cares mentioned above. CNS-C stated the insulin pens are kept in a medication container labeled with the resident's name but there were no labels put on the pens themselves. CNS-C stated insulins are good for 28 days after opening and they stated there should be an opened-on date on them. CNS-C also stated they had not checked medications for labels and expiration dates in the past. The manufacturer's instructions for the use of Humalog Kwikpen (insulin Lispro) injection last revised July 2023, directed the insulin Lispro to be discarded after 28 days, even if it still has insulin left in it.	01890		

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01890	Continued From page 75 The manufacturer's instructions for the use of Lantus soloStar pen injection last revised in 2022, directed the Lantus soloStar pen to be discarded after 28 days, even if it still has insulin left in it. The manufacturer's instructions for the use of Victoza injection last revised July 2023, directed the Victoza to be discarded after 30 days, even if some medicine is left in the pen. The licensee's undated Individualized Medication Management Plan and Record Policy read, " 1. Following completion of the nursing assessment, including an assessment of the resident's need for medication management, the RN develops an individualized medication management record for the resident in conjunction with the resident and/or the resident's representative. The plan must include the following: a. A statement describing the medication management services that will be provided b. Description of how medications will be stored, based on the resident's needs, risk of diversion and consistent with the manufacturer's directions." No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
02310 SS=F	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	02310		

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02310	Continued From page 76 standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards for three of three residents (R1, R2, R3) with hospital bed rails. This resulted in an immediate correction order on May 15, 2024. 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 R1's diagnoses included quadriplegia, unspecified injury at C1 level of cervical spinal cord, anxiety disorder, border line personality disorder bradycardia, hypotension, and pain. R1's Service Plan dated March 2, 2024, indicated R1 received services for bathing, dining, grooming, medication administration, toileting, and transferring. R1's record included Bed Rail Assessment and Resident Consent, which were completed on September 29, 2022, and March 26, 2024. R1's record lacked bed rail assessments which were to be completed every 90 days after the initial assessment or with change of condition.	02310		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 77 R2 R2's diagnoses included diabetes mellitus, personality disorder, morbid obesity, anxiety disorder severe persistent asthma, agitation, depressive disorder, and overactive bladder. R2's Service Plan dated April 3, 2024, indicated R2 received services for, bathing, dining, grooming, medication administration, toileting, skin care, and transferring. R2's record included Bed Rail Assessment and Resident Consent, which were completed on September 20, 2022, September 21, 2023, and March 20, 2023. R2's record lacked bed rail assessments which were to be completed every 90 days after the initial assessment or with change of condition. R3 R3's diagnoses included acquired absence of the right leg below the knee, morbid obesity, hypertension, and diabetes mellitus. R3's Service Plan dated October 5, 2022, indicated R3 received services for, bathing, dining, grooming, medication administration, toileting, skin care, and transferring. R3's record included Bed Rail Assessment and Resident Consent, which was completed on March 26, 2024. R3's record lacked bed rail assessments which were to be completed every 90 days after the initial assessment or with change of condition. The licensee's Bed Rail Assessment and Resident Consent form which was utilized for all residents with a bedrail indicated bedrail	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34952	A. BUILDING: _____ B. WING _____	05/17/2024

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02310	Continued From page 78 assessment was completed semi-annually. On May 15, 2024, at 9:40 a.m., clinical nurse supervisor (CNS)-C stated the bedrail assessments were completed semi-annually. CNS-C stated they received a tool from another surveyor who was surveying a sister facility, and the tool stated to do it regularly therefore they decided to conduct bedrail assessments semi-annually. CNS-C also stated all residents had bedrails on their bed upon admission. On May 15, 2024, at 9:45 a.m., the surveyor observed R1, R2 and R3's hospital bed which each had bilateral half upper side rails. The surveyor wiggled and pulled on all bedrails which were firmly attached to the bed. The Food and Drug Administration's (FDA), A Guide to Bed Safety, dated 2000, and revised April 2010, indicated following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently Asked Questions (FAQs) indicated, "Per the Uniform Assessment Tool, the need for assistive devices, such as bed rails, must be assessed upon initial installation, with each 90-day assessment and change of condition. (Please	02310		

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02310	Continued From page 79 refer to Rule 4659.0150 where it directs assessment of mobility, including ambulation, transfers, and assistive devices.) Bed rail assessment should also be conducted whenever the type of bed rail is changed or if the rails is observed to not maintain a consistent secure attachment to the bed frame." The licensee's Hospital Bed Side Rails Policy dated February 4, 2023, read, " 4. A detailed document on side rails is found at: http://www.fda.gov/downloads/MedicalDevices/DeviceRegulationandGuidance/GuidanceDocuments/ucm072729.pdf. 5. Detailed information from FDA about Side Rail Safety, including information for both health care providers and for consumers and caregivers is found at: http://www.fda.gov/MedicalDevices/ProductsandMedicalProcedures/HomeHealthandConsumer/ConsumerProducts/BedRailSafety/default.htm. The web page for consumers and caregivers can be printed as a handout for facility residents and their families." No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	02310		
02410 SS=E	144G.91 Subd. 13 Personal and treatment privacy (a) Residents have the right to consideration of their privacy, individuality, and cultural identity as related to their social, religious, and psychological well-being. Staff must respect the privacy of a resident's space by knocking on the door and seeking consent before entering, except in an emergency or unless otherwise documented in	02410		

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02410	Continued From page 80 the resident's service plan. (b) Residents have the right to have and use a lockable door to the resident's unit. The facility shall provide locks on the resident's unit. Only a staff member with a specific need to enter the unit shall have keys. This right may be restricted in certain circumstances if necessary for a resident's health and safety and documented in the resident's service plan. (c) Residents have the right to respect and privacy regarding the resident's service plan. Case discussion, consultation, examination, and treatment are confidential and must be conducted discreetly. Privacy must be respected during toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure privacy was maintained for medical information for two of three residents (R1, R2) with 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 a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On May 13, 2024, at 12:35 p.m., the surveyor observed a discharged/deceased resident's (R6)	02410		

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02410	Continued From page 81 Resident Care Schedule for Daily Living Activities updated on March 23, 2021, on R1's door, posted on the door from inside of the room. The document included residents personal care information for day and night staff's reference for helping the resident with activities of daily living. On May 13, 2024, at 12:35 p.m., the surveyor observed R1's Resident Care Schedule for Daily Living Activities updated on September 23, 2022, posted on the door from the inside of R2's room. On May 14, 2024, at 11:12 a.m., the surveyor observed the licensee removed R1's Care Schedule from the inside of R2's door, but had placed R2's Resident Care Schedule for Daily Living Activities updated on April 11, 2024, on the outside of R2's door. The document included residents personal care information for day and night staff's reference for helping the resident with activities of daily living. The document included the following personal content: -R2's name -Resident is to be transferred to electric wheelchair with 2+ assist, may do 1+ assist to return to bed. -Offer emotional support and active listening as needed. Resident is often verbally abusive and may be physically abusive. -Monitor skin folds for reddened skin or irritation; PRN topical powder. -When in bed, place a pillow under legs to float heels to prevent pressure ulcer formation. -Resident prefers to use incontinence products for voiding urine and having bowel movements; does not want to use a bedpan. -Do not give sharp objects. -Mechanical soft texture foods until dentures arrive.	02410		

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02410	Continued From page 82 On May 15, 2024, at 9:45 a.m., clinical nurse supervisor (CNS-C) stated the Resident Care Schedule for Daily Living Activities should not be posted on the outside, it should be posted on the inside of the room for the resident's privacy. CNS-C also stated they were not aware R1 and R2 had the wrong care schedules posted on their doors. The licensee's undated Resident Privacy Rights policy, read "A copy of the resident privacy rights and the Assisted Living Bill of Rights will be presented to all residents at the time of admission. PURPOSE: To inform residents of the facility of their rights of privacy. To accommodate resident privacy rights as specified in the privacy rule of the Health Information Portability and Accountability Act (HIPAA) regulation." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02410		

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

Type: Follow-Up
Date: *05/27/24*
Time: 14:58:00
Report: 1043241135

Food and Beverage Establishment Inspection Report

Location:
Our Caring Hands LLP
9220 207th Street West
Lakeville, MN55044
Dakota County, 19

Establishment Info:
ID #: 0038583
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 9524869292
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 previously issued on 05/13/24 have NOT been corrected.

3-300C Protection from Contamination: equipment/utensils, consumers

3-304.14B

MN Rule 4626.0285B Wiping cloths used for wiping counters and other equipment surfaces must be held in an approved sanitizing solution and laundered daily.

WET CLOTHS OBSERVED TO BE STORED ON THE SINK DIVIDER. ADVISED STAFF TO STORE CLOTHS IN A SANITIZER BUCKET IN BETWEEN USES OR USE A DRY, CLEAN CLOTH EACH TIME. SEE COMMENT FOR MORE DETAILS. COMPLY WITH ABOVE RULE.

Issued on: 05/13/24 *Comply By: 05/13/24*

No NEW orders were issued during this inspection.

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

This facility was originally inspected on the week of 5/13/24 with Dee Mosissa as the lead Health Regulation Division Nurse Evaluator.

A follow-up report was written to clear the previous order on the dish machine written on 5/13/24. The test result was provided via email by Ann Murgasen on 5/27/24. The remaining order on this report will be assessed during the next inspection.

Using chlorine as a sanitizer was discussed as an option for storing in-use wet cloths. Chlorine must be unscented. The chlorine solution in the sanitizer bucket should measure between 50-100 ppm. A test kit must be provided to measure the concentration of the chlorine solution.

**Foods cooked by the facility staff should be fully cooked and prepared for same day service only with leftovers discarded.

Type: Follow-Up
Date: *05/27/24*
Time: 14:58:00
Report: 1043241135
Our Caring Hands LLP

Food and Beverage Establishment Inspection Report

**This facility has a residential kitchen with residential equipment and wooden cabinetry. The kitchen finishes and surfaces are well maintained. Contact Health Regulation Division for plan review when facility undergoes remodeling.

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 1043241135 of 05/27/24.

Certified Food Protection Manager Gabriella A. Nowrang

Certification Number: FM111879 Expires: 06/22/25

Inspection report reviewed with person in charge and emailed.

Signed:_____

Ann Murgasen
PIC

Signed: Blia Lor

Blia Lor
Public Health Sanitarian I
651-355-0641
blia.lor@state.mn.us