Electronically Delivered

October 22, 2024

Licensee
Total Home Health Services LLC
6949 Idaho Avenue North
Brooklyn Park, MN 55428

RE: Project Number(s) SL36648015

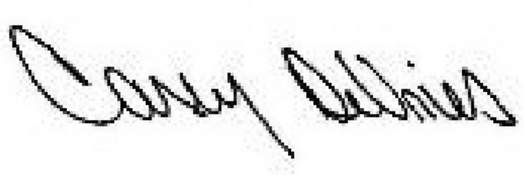
Dear Licensee:

On October 8, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the July 11, 2024, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,



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

JMD

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

AMENDED

Electronically Delivered

August 13, 2024

Licensee
Total Home Health Services LLC
6949 Idaho Avenue North
Brooklyn Park, MN 55428

RE: Project Number(s) HL366484414C & SL36648015

Dear Licensee:

Please note: This letter amends the previous letter dated August 6, 2024. Specifically, complaint investigation (HL366484414C) has been added to this letter and the State Form to accurately reflect the findings of the survey and complaint investigation.

The Minnesota Department of Health (MDH) completed a survey and complaint investigation on July 11, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey and complaint investigation, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

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

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

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

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

St - 0 - 0470 - 144g.41 Subdivision 1 - Minimum Requirements - $3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $3,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

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

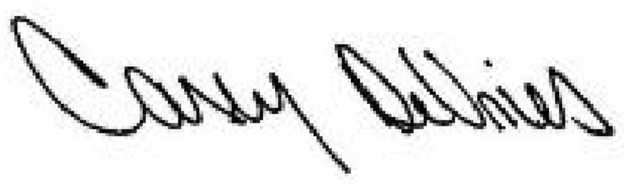
To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms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

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

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

If you have any questions, please contact me.

Sincerely,



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

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36648	A. BUILDING: _____ B. WING _____	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOTAL HOME HEALTH SERVICES LLC	6949 IDAHO AVENUE NORTH BROOKLYN PARK, MN 55428

(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: SL36648015-0 HL366484414C On July 8, 2024, through July 11, 2024, the Minnesota Department of Health conducted a full survey and complaint investiatgion at the above provider, and the following correction orders are issued. At the time of the survey, there were three residents all of whom received services under the provider's Assisted Living Facility license. An immediate correction order was identified on July 9, 2024, issued for SL36648015-0 and HL366484414C, tag identification 0470. On July 10, 2024, the immediacy of correction order 0470 was removed, however non-compliance remained, and the scope and level remained unchanged. An immediate correction order was identified on	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	

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0 000	Continued From page 1 July 10, 2024, issued for SL36648015 tag identification 0820. On July 11, 2024, the immediacy of correction order 0820 was removed, however non-compliance remained, and the scope and level remained unchanged	0 000		
0 110 SS=C	144G.10 Subdivision 1a Assisted living director license required Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the licensed assisted living director (LALD) was listed as the Director of Record for the licensee. This had the potential to affect all the licensee's residents, staff, and visitors. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). These findings include: On July 8, 2024, at 7:41a.m. and 10:17 a.m., the surveyor observed the Board of Executives for	0 110		

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0 110	Continued From page 2 Long-Term Services and Supports (BELTSS) website which indicated licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C held a current assisted living director license, however, was not listed as the director of record for the licensee. On July 8, 2024, at 10:21 a.m., LALD/CNS-C stated they were not aware they needed to be listed as the director of record on BELTSS. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 110		
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;	0 250		

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0 250	Continued From page 3 (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 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 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	0 250		

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0 250	Continued From page 4 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. 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 July 8, 2024, at 10:21 a.m., licensed assisted living director/clinical nurse supervisor (LALD/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 four and five 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.	0 250		

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0 250	Continued From page 5 - 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 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.	0 250		

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0 250	Continued From page 6 - 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 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 six was electronically signed by LALD/CNS-C on July 1, 2023. The licensee had an assisted living license issued on September 1, 2023, with an expiration date of August 31, 2024.	0 250		

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0 250	Continued From page 7 The licensee failed to ensure the following policies and procedures were developed and/or implemented: - orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; - 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; - 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; - medication management; and - delegation of tasks by registered nurses or licensed health professionals. On July 10, 2024, at approximately 9:09 a.m., LALD/CNS-C confirmed the licensee provided assisted living services but failed to implement corresponding policies and procedures, as required. As a result of this survey, the following orders were issued 0110, 0460, 0470, 0480, 0485, 0550, 0580, 0650, 0660, 0680, 0700, 0780, 0790, 0800, 0810, 0820, 1500, 1530, 1620, 1730, 1760, 1820, 1880, 1890, and 2320 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.	0 250		

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0 250	Continued From page 8 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 250		
0 460 SS=F	144G.41 Subdivision 1 Minimum requirements (5) provide a means for residents to request assistance for health and safety needs 24 hours per day, seven days per week; (6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract; (7) permit residents access to food at any time; (8) allow residents to choose the resident's visitors and times of visits; (9) allow the resident the right to choose a roommate if sharing a unit; (10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living facility must not lock a resident in the resident's unit; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide a means for residents to request assistance for health and safety needs 24 hours a day, seven days a week. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when	0 460		

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0 460	Continued From page 9 problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On July 8, 2024, from 9:32 a.m., to 10:07 a.m., during a facility tour, the surveyor observed a two-level home and did not observe call lights, call pendants, or bells located in the rooms of the residents or in the common areas. On July 8, 2024, at 10:28 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated they did not provide means for the residents to request assistance for health and safety. LALD/CNS-C stated the licensee would have a system to request assistance "if they [staff] were distanced from the client [resident] but as you can see the staff is right here. They just call out and we are able to hear. The person in the basement is real stable. They [residents] are all stable and aware." LALD/CNS-C stated residents were physically able to come ask for assistance, and they believed the licensee had bells, however, did not place with the residents because they thought the bells were not needed. The surveyor inquired if the residents had been offered the call bell. LALD/CNS-C stated no. LALD/CNS-C stated they would locate the bells and place them in the resident's rooms. On July 9, 2024, at 8:24 a.m., R3 stated they ambulated out of the room if they needed assistance or could yell however, they mainly came out of the room if they requested assistance. On July 10, 2024, at 7:41 a.m., the surveyor	0 460		

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	36648	A. BUILDING: _____ B. WING _____	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOTAL HOME HEALTH SERVICES LLC	6949 IDAHO AVENUE NORTH BROOKLYN PARK, MN 55428

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0 460	Continued From page 10 inquired how R2 requested assistance. R2 stated, "I don't want to answer that question." From July 8, 2024, to July 10, 2024, the surveyor did not see bells within the assisted living facility. The licensee's Staffing policy dated February 3, 2023, indicated residents were provided with a means to request assistance for health and safety needs 24 hours per day seven days per week. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 460		
0 470 SS=G	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster 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;	0 470		

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0 470	Continued From page 11 (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 that one or more persons were 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. This impacted one of three residents (R1) who received care from the licensee. 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: R1 admitted to the licensee on February 20, 2024, and began receiving assisted living services. R1 resided in the lower level of the facility. R1's diagnosis included schizophrenia (mental disorder characterized by delusions, hallucinations, disorganized thoughts, speech,	0 470		

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0 470	Continued From page 12 and behavior). R1's service plan signed February 20, 2024, indicated R1 received assistance with medication administration, meals, behavior management, and reminders for activities of daily living. On July 8, 2024, at 8:53 a.m., the surveyor arrived at the licensee's facility and observed no cars in the driveway, no cars in the garage, and no human activity through the windows on the upper level of the facility. The surveyor continued to ring the doorbell, knock on the door, and call the licensee with no response until 9:20 a.m. On July 8, 2024, at 9:20 a.m., a white Equinox pulled into the driveway. The surveyor observed unlicensed personnel (ULP)-A and visitor (V)-E exit the vehicle. ULP-A stated V-E had a flat tire, and their boss would pick V-E up from the facility. The surveyor inquired if the facility had active residents. ULP-A stated they had three residents with similar working hours and all three were at work. The surveyor inquired if all three were at work right now. ULP-A stated they took two to work however, one was at their grandparent's house for the weekend and the grandparent would drop them off later at the facility. On July 8, 2024, from 9:32 a.m. to 10:10 a.m., the surveyor observed a two-level facility. The surveyor first observed the first level of the facility. There were no residents in the rooms. At approximately 10:06 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C arrived at the facility. At 10:07 a.m., LALD/CNS-C stated there was a bedroom in the basement to observe however, the resident arrived at the facility when the surveyor was touring another resident room. The surveyor walked down the	0 470		

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0 470	Continued From page 13 staircase to the lower level and knocked on R1's door. R1 stated they were sleeping and did not want to be interrupted with a tour or interview. On July 8, 2024, at 11:15 a.m., LALD/CNS-C stated they had two residents who worked at the same time and staff transported them together, so no one was left unattended at the facility. LALD/CNS-C stated R1 was not in the house this morning that is why they were able to drop off the other two residents. LALD/CNS-C stated residents were not to be left in the house unattended. On July 9, 2024, at 6:51 a.m., ULP-A stated if R1 did not work and the other two residents needed to be transported to work, they would have R1 ride with them. ULP-A stated R1 liked to pick up McDonalds for breakfast on days they did not work and R1 worked on Friday and Saturdays. On July 9, 2024, at 6:53 a.m., the surveyor observed ULP-B enter the facility. On July 9, 2024, at 7:32 a.m., R2 stated staff were present when they were at the facility. On July 9, 2024, at 7:39 a.m., R1 stated they worked at a restaurant and went to their grandparents home every two weeks. The surveyor inquired when they returned to the facility. R1 stated Sunday. The survey inquired what they did yesterday morning. R1 stated "I was not up remember you tried knocking on my door." R1 stated he did not leave the facility on June 8, 2024. On July 9, 2024, the surveyor observed R1, and R2 exit the facility with ULP-A. R3 was in the room sleeping and ULP-B was attending to other	0 470		

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0 470	Continued From page 14 tasks in the facility. On July 9, 2024, at 7:49 a.m., ULP-B stated they work every Monday, Tuesday, Thursday, and Friday morning so the other ULP could transport residents to their jobs. The surveyor inquired why they were not here on July 8, 2024. ULP-B stated they had a dental appointment, and their understanding was R1 was not at the house. On July 9, 2024, at 7:52 a.m., grandparent (GP)-F stated they did not want to be interviewed until R1 was on the phone with the surveyor. On July 9, 2024, at 8:24 a.m., R3 stated the other two resident did not come with them every time to get dropped off or pick up from work however, other residents would come in the car at times so they could go to the store. R3 stated they were left alone once where they had to call an ambulance because there was no one able to assist them at the facility. On July 9, 2024, at 8:39 a.m., ULP-A and R1 returned to the facility. ULP-A than left the facility again. On July 9, 2024, at 8:51 a.m., GP-F stated they dropped off R1 at the facility at 1:30 p.m. on July 7th, 2024. On July 9, 2024, at 11:28 a.m., LALD/CNS-C stated R1 was their own person and knew how to evacuate the house in case of an emergency. LALD/CNS-C stated there was supposed to be a sign in and out sheet the resident used to keep track of where they were located. The surveyor asked to see the document. LALD/CNS-C stated they were unable to locate the document. LALD/CNS-C stated staff should be looking at the	0 470		

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0 470	Continued From page 15 sheets to see who was in the facility and who was out for the day. LALD/CNS-C stated staff were suppose to wait at the facility until another staff member arrived if they needed to transport a resident. The surveyor inquired again if LALD/CNS-C saw R1 walk into the facility. LALD/CNS-C stated when they entered the facility, they saw R1 in the staircase leading to the basement they assumed R1 had been dropped off by their grandparents. LALD/CNS-C stated another staff member said it was ok for ULP-B not to come to the facility when they were suppose to. On July 9, 2024, at 1:49 p.m., the surveyor attempted to contact ULP-A via phone for an interview. There was no answer, and the surveyor was unable to leave a voice message. The licensee's Incident Report Log included an incident on June 1, 2024, that indicated staff left a resident unattended at the facility and the licensee trained staff not to leave residents unattended. The licensee's Incident Report dated June 1, 2024, indicated R3 was left unattended at the facility when they believed they had urinated out a parasite. R3 attempted to call for staff's help however, staff were not present. R3 than called 911 and staff arrived back at the facility after law enforcement arrived on the scene. The action that was taken read "staff were talked to -to never lave residents unattended for any reason w/out informing the supervisor, manager, or a nurse. Wait for other staff to get here." The licensee's undated staffing plan indicated the licensee's had three scheduled shifts which included 7:00 a.m. to 5:00 p.m., 3:00 p.m., to	0 470		

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0 470	Continued From page 16 11:00 p.m., and 11:00 p.m. to 9:00 a.m. The schedule indicated there were overlapping staff coverage between the hours of 7:00 am to 9:00 a.m., and 3:00 p.m. to 5:00 p.m. where there were two staff present at the facility. The licensee's Staffing policy dated February 3, 2023, indicated residents were provided with a means to request assistance for health and safety needs 24 hours per day seven days per week and the ULP would respond to resident requests for assistance as soon as possible. In addition, the clinical nurse supervisor (CNS) would prepare and implement a 24-hour daily staffing plan that ensured adequate staffing to meet the resident needs at all times including reasonably and foreseeable needs. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE In addition, the licensee failed to develop and implement a written staffing plan that included an evaluation completed by the clinical nurse supervisor (CNS) (as indicated in Minnesota Administrative Rule 4659.0180) at least twice a year. This had the potential to affect all residents, staff, and visitors. The findings include: The licensee held an assisted living license. The facility was licensed for a capacity of three residents. On July 9, 2024, at 12:36 p.m., LALD/CNS-C provided the surveyor with the licensee's staffing plan. The licensee's undated staffing plan indicated the licensee's had three scheduled	0 470		

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0 470	Continued From page 17 shifts which included 7:00 a.m. to 5:00 p.m., 3:00 p.m., to 11:00 p.m., and 11:00 p.m. to 9:00 a.m. The schedule indicated there was overlapping staff coverage between the hours of 7:00 a.m. to 9:00 a.m., and 3:00 p.m. to 5:00 p.m. where there were two staff present at the facility. The staffing plan lacked an evaluation conducted by the CNS, to be conducted at least twice a year. LALD/CNS-C stated they reviewed the staffing plan however, they did not write a date. The licensee's Staffing policy dated February 3, 2023, indicated the CNS would prepare and implement a 24-hour daily staffing plan that ensured adequate staffing to meet residents' needs at all times, including reasonably foreseeable needs. No further information was provided.	0 470		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according 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	0 480		

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0 480	Continued From page 18 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 July 8, 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		
0 485 SS=F	144G.41 Subdivision 1. (13)(i)(A)and(C) Minimum Requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (A) menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes; and (C) the facility cannot require a resident to include and pay for meals in their contract; (ii) weekly housekeeping;	0 485		

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0 485	Continued From page 19 (iii) weekly laundry service; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure at least three nutritious meals daily were served according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 R1 admitted to the licensee on February 20, 2024, and began receiving assisted living services. R1's service plan signed February 20, 2024, indicated R1 received assistance with housekeeping, transportation, laundry, meals, medication administration, vital signs monthly, behavior management, and activity of daily living reminders. R2 R2 admitted the licensee on February 20, 2024, and began receiving assisted living services.	0 485		

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0 485	Continued From page 20 R2 service plan dated February 20, 2024, indicated R2 received assistance with medication management, monthly vital signs, housekeeping, transportation, and meals. R3 R3 admitted to the licensee on April 19, 2024, and began receiving assisted living services. R3's service plan signed April 19, 2024, indicated R3 received assistance with activity of daily living reminders, meals, medication administration, vital signs monthly, behavior management, housekeeping, transportation, and laundry. On July 8, 2024, during a facility tour at 9:32 a.m., the surveyor observed an undated Weekly Menu posted on the licensee's refrigerator in the kitchen. Unlicensed personnel (ULP)-A stated they always had bananas and apples available for the residents. The surveyor observed two apples left in the fruit basket. ULP-A stated the licensee received new fruit every Monday. The surveyor observed the licensee's indoor and outdoor refrigerators and cabinets and observed the following food items, turkey lunch meat-two containers, hot peppers, garlic, yogurt, milk, meatless spaghetti sauces, breads including buns, pop, apple juice, coconut, condiments, frozen shrimp, frozen hamburger patties, fish sticks, pizzas, French fries, macaroni and cheese, penne noodles, pancake mix, spices, cereal boxes, oatmeal, peanut butter, frozen chicken breasts, and water. The menu included seven days, Monday through Sunday and included breakfast, lunch, dinner, and two snacks. The menu included the following meals and snacks: - snack Monday through Sunday twice per day was "animal crackers, apply (sic) or banana";	0 485		

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0 485	Continued From page 21 - Thursday breakfast: oatmeal, milk, banana, or cereal with milk; - Sunday breakfast: waffle with banana and milk; - Monday lunch: spaghetti with spaghetti sauce, lettuce, juice; - Wednesday lunch: macaroni with spaghetti sauce, lettuce, with drink; - Tuesday dinner: pizza with mixed vegetable; - Wednesday dinner: pancake with milk and fruits; - Friday dinner: waffle with milk and fruits; - Saturday dinner: macaroni and cheese with lettuce and juice; and - Sunday dinner: pizza with vegetable and juice. In addition, eggs were listed on the menu for breakfast on Monday, Tuesday, Wednesday, Saturday. The surveyor did not see the following food items listed on the menu: -animal crackers; - lettuce; -eggs; and -mixed vegetables either frozen or fresh. The menu lacked a date of service and lacked a protein source. The menus lacked at least three nutritious meals daily according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines. On July 8, 2024, at 1:47 p.m., licensed assisted living director/clinical nurse supervisor stated they posted a menu however, they thought the menu could just list the days of the week. LALD/CNS-C stated fruit was always available on site. LALD/CNS-C stated they did provide meal substitutions that included hot dog, hamburger, macaroni and cheese, pizza, and lunch meat. The surveyor reviewed the menu with	0 485		

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0 485	Continued From page 22 LALD/CNS-C. LALD/CNS-C stated for breakfast residents could choose turkey lunch meat, hot dog or breakfast sausages to add for protein. The surveyor stated to LALD/CNS-C they did not observe sausages or hot dogs for the residents. LALD/CNS-C stated, "they must have ran (sic) out." In addition, LALD/CNS-C stated they were unsure why the menu lacked a protein source. On July 8, 2024, the surveyor did not observe lunch offered or made. There was one resident in the facility over the lunch hour. On July 9, 2024, at 7:32 a.m., the surveyor observed R2 pour and consume a bowl of cereal and milk. On July 9, 2024, at 8:24 a.m., R3 stated for breakfast they received waffles, cereal, or oatmeal. The surveyor inquired if they received breakfast sausages, breakfast sandwiches, or hot dogs. R2 stated no. The surveyor listed out multiple protein sources to R2 and inquired if they received any of the protein sources for lunch or dinner. R3 stated they received a protein source sometimes at lunch and dinner. R3 stated they always had apples or bananas in the facility. On July 9, 2024, at 8:39 a.m., the surveyor observed R1 return to the facility with McDonalds for breakfast. On July 9, 2024, the surveyor did not observe staff offer R1 a lunch. R1 remained in their room after they ate McDonalds. On July 10, 2024, at 7:40 a.m., the surveyor observed R2 eating cereal with milk and a staff member cooked oatmeal.	0 485		

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	36648	A. BUILDING: _____ B. WING _____	07/11/2024

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0 485	Continued From page 23 On July 10, 2024, at 9:09 a.m., LALD/CNS-C stated the residents were independent and had the choice of what they ate. LALD/CNS-C stated the residents worked and had money and could purchase other items. LALD/CNS-C stated the licensee provided groceries and the residents were involved with grocery shopping. The USDA titled My Plate Dietary Guidelines for Americans dated 2020- 2025, recommended men between 19 to 59 years old should receive six to seven ounces equivalent towards their daily recommended amount of protein. The licensee's Food Service policy dated February 3, 2023, indicated meals were prepared according to the recommended dietary allowances in the USDA guidelines including seasonal fresh fruit and fresh vegetables. In addition, menus were prepared one week in advance and made available to all residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities	0 550		

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0 550	Continued From page 24 and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post required information related to the licensee's grievance procedure to include contact information for the Office of Ombudsman for Long-Term Care (OOLTC) and Mental Health and Developmental Disabilities (OOMHDD). 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 client'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 July 8, 2024, at 9:32 a.m., during facility tour, the surveyor observed there was no evidence of the contact information for the state and applicable regional OOLTC and OOMHDD. On July 8, 2023, at 10:55 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C verified they licensee did not post	0 550		

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0 550	Continued From page 25 the contact information for OOLTC or OOMHDD. LALD/CNS-C stated the thought they had posted the required information however; it was not posted. The licensee's Grievance policy dated February 3, 2024, read, "2. A copy of the grievance procedure is conspicuously posted in the residence with the following information: o Name, phone number and email contact information for the individuals who are responsible for handling resident complaints o Contact information for the state and any regional Office of Ombudsman for Long-Term-Care o Contact information for the Office of Ombudsman for Mental Health and Developmental Disabilities o Contact information for the Minnesota Adult Abuse Reporting Center o Contact information for the Minnesota Department of Health, Office of Health Facility Complaints if an individual has a complaint about the facility or person providing services." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes	0 580		

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0 580	Continued From page 26 in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to implement and maintain a quality management program (QMP) appropriate to the size of the facility and relevant to the type of services provided. This had the potential to affect all residents, staff, and visitors. 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 July 8, 2024, at approximately 10:16 a.m., during the entrance conference, licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated they licensee did not have a quality management program because the current residents admitted after February of 2024. LALD/CNS-C stated they did not have one prior due to not having residents for a prolonged period of time. On July 10, 2024, at 8:12 a.m., LALD/CNS-C	0 580		

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0 580	Continued From page 27 stated prior to the three current residents, there last resident they provided services to was in June of 2023. The licensee's Quality Improvement policy dated July 13, 2019, indicated the licensee had established a quality improvement program based on the agency size and appropriate to its medication management program in order to assure that effective, comprehensive, and appropriate plans were operational for all medication management clients within the organization. In addition, documentation of the organization's quality improvement program was to be maintained for at least two years and would be provided to the commissioner at the time of survey, investigation or renewal as requested. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 580		
0 650 SS=F	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	0 650		

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0 650	Continued From page 28 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 the employee record contained the required content for three of three employees (unlicensed personnel (ULP-A, ULP-B, registered nurse (RN)-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 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 ULP-A was hired on February 20, 2024, to provide direct cares and services to residents. ULP-A's employee record lacked the following content: - current job description, including qualifications, responsibilities, and identification of staff persons providing supervision;	0 650		

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0 650	Continued From page 29 - training on the following: - prevention of falls for providers working with elderly or individuals at risk of falls; and - communication skill include preserving the dignity of the resident and show respect for the resident and the residents preferences, cultural background, and family. - competencies evaluations on the following: - range of motion and positioning; - safe transfer techniques and ambulation; - stand by assistance techniques and how to perform them; and - appropriate and safe techniques in personal hygiene and grooming including hair care, bathing, care of teeth, gums and oral prosthetic devices, care and use of hearing aides, and dressing and assisting with toileting. - training and competency evaluation on unplanned times away from home. ULP-A's employee record included areas to document the training and competency evaluations listed above with the exception of unplanned time away however, they were marked not applicable. ULP-B ULP-B was hired on February 23, 2024, to provide direct cares and services to residents. ULP-B's employee record lacked the following content: - current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; - training on the following: - prevention of falls for providers working with elderly or individuals at risk of falls; and - communication skill include preserving the dignity of the resident and show respect for the	0 650		

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0 650	Continued From page 30 resident and the residents preferences, cultural background, and family. - competencies evaluations on the following: - range of motion and positioning; - safe transfer techniques and ambulation; - stand by assistance techniques and how to perform them; and - appropriate and safe techniques in personal hygiene and grooming including hair care, bathing, care of teeth, gums and oral prosthetic devices, care and use of hearing aides, and dressing and assisting with toileting. - training and competency evaluation on unplanned times away from home. ULP-B's record included areas to document the training and competency evaluations listed above with the exception of unplanned time away however, they were marked not applicable. On July 10, 2024, at 7:44 a.m. ULP-B stated they were trained and passed the competency evaluations listed above however, the current residents did not require that assistance. RN-D RN-D was hired to the licensee on March 23, 2020, to provide direct oversite to unlicensed personnel (ULP) and to provide direct care to residents. RN-D's employee record lacked the following required content: - current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; and - documentation of annual performance reviews that identify areas of improvement needed and training needs.	0 650		

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0 650	Continued From page 31 On July 9, 2024, at 10:18 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated they believed ULP-A, ULP-B, and RN-A took their job description home with them. On July 9, 2024, at 10:37 a.m., LALD/CNC-C stated they trained and completed competency evaluations for all of the topics listed above however, they did not have documentation of it. LALD/CNS-C stated they put not applicable on the trainings and competency evaluations because the residents at the facility did not require those skills. On July 9, 2024, at 10:40 a.m., LALD/CNS-C stated they trained and completed competency evaluation for unplanned time away from home however, had no documentation in the employee record. The licensee's Personnel Records dated February 3, 2023, read, "2. At a minimum, all documents related to the following are kept in the personnel record, as applicable to job requirements o Evidence of current professional licensure, registration or certification o Results of background studies o Records of annual training and infection control training o Documentation of orientation o Documentation of supervision, as applicable o Performance reviews o Competency evaluations o Signed job description o Documentation of annual performance reviews identifying areas of improvement needed and training needs".	0 650		

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	36648	A. BUILDING: _____ B. WING _____	07/11/2024

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0 650	Continued From page 32 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 660 SS=E	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 maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), which included a two-step tuberculin skin test (TST) or other evidence of TB screening such as a blood test for two of three employees (unlicensed personnel (ULP)-A, ULP-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 660		

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	36648	A. BUILDING: _____ B. WING _____	07/11/2024

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0 660	Continued From page 33 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: The facility TB risk assessment form dated June 24, 2024, indicated the facility was at a low risk for TB transmission. ULP-A ULP-A was hired on February 20, 2024, to provide direct cares and services to residents. ULP-A's employee record included a health history and symptom screening completed on February 20, 2024. The document had a section for the two-step TST however, was left uncompleted. ULP-B ULP-B was hired on February 23, 2024, to provide direct cares and services to residents. ULP-B's employee record included a health history and symptom screening completed on February 23, 2024. The document had a section for the two-step TST however, was left uncompleted. ULP-A and ULP-B's records lacked a two-step tuberculin skin test (TST) or other evidence of TB screening such as a blood test. On July 9, 2024, at 10:37 a.m., licensed assisted	0 660		

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0 660	Continued From page 34 living director/clinical nurse supervisor (LALD/CNS)-C verified ULP-A's employee record lacked TB screening. LALD/CNS-C stated they asked ULP-A to provide one to them however, ULP-A did not bring one in. LALD/CNS-C stated once they filed the new hire paperwork, they forgot to follow up with ULP-A on receiving the TB screen. On July 9, 2024, at 10:57 a.m., the surveyor inquired if ULP-B completed a TB screening. LALD/CNS-C verified ULP-B lacked a TB screening. LALD/CNS-C stated, "I don't know why. She is supposed to have one in the record." The CDC's document titled Baseline Tuberculosis Screening and Testing for Health Care Personnel dated December 19, 2023, recommended all United States health care personnel should be screened for TB upon hire. This process should include risk assessment, symptom evaluation, and TB blood test or TB skin test. The licensee's Tuberculosis Screening/Prevention policy dated February 3, 2023, indicated the licensee would observe the recommended precautions related to TB prevention as identified by the CDC and the Minnesota Department of Health (MDH). No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following	0 680		

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0 680	Continued From page 35 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. 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	0 680		

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0 680	Continued From page 36 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 lacked evidence of the following required content: - annual update; - hazard vulnerability risk assessment; - quarterly review of missing resident policy; - emergency plan (EP) program patient population to include transportation and staff who would assume specific roles in another's absence; - polices and procedures for evacuation to include transportation, alternate evacuation location; - arrangement with other facilities; - contact names and information; - emergency officials contact information to include state licensing and certification agency; and - emergency prep testing requirements. On July 10, 2024, at 8:36 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated the licensee's EPP was created in January of 2022 and was reviewed annually in January. LALD/CNS-C stated they did not document when the EPP was reviewed or created. LALD/CNS-C stated they reviewed the missing resident policy yearly and was unaware of the requirement to review the policy quarterly. LALD/CNS-C stated they would use their own vehicles for transportation however, they did not document this in the EPP. LALD/CNS-C stated the primary evacuation location was a backyard of a neighbor, they did not have an alternative site, and they did not have written arrangements with other facilities.	0 680		

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	36648	A. BUILDING: _____ B. WING _____	07/11/2024

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0 680	Continued From page 37 The licensee's Emergency Preparedness policy dated February 3, 2023, indicated the licensee would have an identified plan in place to assure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupts services. In addition, a disaster drill would be conducted at the residence at least annually and the results of the drill would be documented. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 700 SS=F	144G.43 Subdivision 1 Resident record (b) Resident records, whether written or electronic, must be protected against loss, tampering, or unauthorized disclosure in compliance with chapter 13 and other applicable relevant federal and state laws. The facility shall establish and implement written procedures to control use, storage, and security of resident records and establish criteria for release of resident information. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure personal health and medical information was kept private for two of three residents (R1, R3) and three home care clients (C4, C5, C6). 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	0 700		

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0 700	Continued From page 38 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). These finding include: On July 8, 2024, at 9:25 a.m., the surveyor entered the licensee's facility with unlicensed personnel (ULP)-A and visitor (V)-E. R1 was in their room for an unknown period time without staff members in the facility. ULP-A stayed near the surveyor while V-E sat on the living room couch. On July 8, 2024, at 9:32 a.m., the surveyor began to tour the facility. ULP-A assisted the surveyor in showing them the kitchen and the outdoor refrigerator located in the detached garage. When the surveyor reentered the facility after observing the garage, the surveyor opened a closet door located near the front door and living room, next to a dining room table. The surveyor observed R1, R3, C4, C5, and C6's full medical records and R1, R2, and R3's medications. The surveyor inquired why the closet door was not locked. ULP-A stated, "I didn't want to waste my time." the door was "stuck", and they were unable to get the door to lock. ULP-A stated they were late for transporting two residents to work and were going to fix it when they returned however, the surveyor was at the facility. On July 8, 2024, at approximately 10:21 a.m., during the entrance conference. Licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated the closet that contained medications and medical records should be	0 700		

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0 700	Continued From page 39 locked when staff members were not present. LALD/CNS-C stated ULP were trained to keep the closet door locked. The licensee's Privacy of Protected Health Information policy dated February 3, 2023, indicated the licensee shall protect the privacy of its resident's personal health information. In addition, no clinical records or personal health information about residents would be accessible in public areas. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 700		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to	0 780		

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0 780	Continued From page 40 operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide interconnected smoke alarms and a smoke alarm outside in the immediate vicinity of all sleeping rooms throughout the facility. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). Findings include: Interconnection On a facility tour on July 10, 2024, at 11:45 a.m., with licensed assisted living director/ clinical nurse supervisor (LALD/CNS)-C, and unlicensed personnel (ULP)-B, it was observed that smoke alarms were not interconnected so activation of one alarm activates all alarms throughout the facility. During the tour the alarms were tested and alarmed individually but there were no alarms interconnected so activation of one alarm activates alarms throughout the facility.	0 780		

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0 780	Continued From page 41 All dwelling units required to have multiple smoke alarms are required to have interconnected alarms so activation of one alarm activates all alarms within the dwelling unit. During the tour the smoke alarms were tested and LALD/CNS-C, and ULP-B, verified the smoke alarms were not interconnected so activation of one alarm activates all alarms throughout the facility. Outside Sleeping Rooms On the same tour it was also observed that smoke alarms were not provided outside in the immediate vicinity of sleeping room number 4 in the lower level. There was a smoke alarm in the lower level, but it was located remotely away from the outside of resident room number 4. Smoke alarms are required to be installed outside in the immediate vicinity of all sleeping rooms. During the tour LALD/CNS-C, and ULP-B, verified smoke alarms were not installed outside in the immediate vicinity of resident room number 4 in the lower level of the facility. TIME PERIOD FOR CORRECTION: Two (2) days	0 780		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3	0 790		

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0 790	Continued From page 42 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide or maintain fire extinguishers as required throughout the facility. This deficient condition had the ability to affect all staff, visitors, and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) 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 a facility tour on July 10, 2024, at 12:10 p.m., with licensed assisted living director/ clinical nurse supervisor (LALD/CNS)-C, and unlicensed personnel (ULP)-B, it was observed that the required fire extinguisher was located under the kitchen sink cabinet with no sign indicating the location of the extinguisher. The provided extinguisher was still in the manufacture packaging, was not mounted at least 4 inches off the floor, and had a date of manufacture of 2022 with no documentation of annual maintenance or monthly inspections.	0 790		

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0 790	Continued From page 43 At least one fire extinguisher with minimum 2-A:10-B:C rating is required to be provided, mounted, maintained, and located within 75 feet of travel throughout the facility. Fire extinguishers are required to be mounted at least 4 inches off the floor and not higher than 60 inches from the floor to the top of the extinguisher. Documentation is required to demonstrate fire extinguishers have been inspected by facility personnel monthly, and annually replaced with a new extinguisher (of current year manufacture date) or serviced by a certified technician. During interview on July 10, 2024, at 12:15 p.m., LALD/CNS-C, and ULP-B, verified this deficient finding. TIME PERIOD FOR CORRECTION: Two (2) days	0 790		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the facility's physical environment in a continuous state of good repair	0 800		

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0 800	Continued From page 44 and operation regarding the health, safety, and well-being of the residents. 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). Findings include: On a facility tour on July 10, 2024, at 11:30 a.m., with licensed assisted living director/ clinical nurse supervisor (LALD/CNS)-C, and unlicensed personnel (ULP)-B, the surveyor made the following observations of facility disrepair: The door seal on the strike side door jamb was coming off and not sealing the door from the weather. The screen and storm window were falling out of the storm window/ screen frame on the outside of the window in resident sleeping room number 1. The light switch cover was in need of repair in the main floor bathroom. There was moisture damage from water on the ceiling in the shower of the main floor bathroom. The top left corner of the emergency escape and rescue window was sticky and hard to open in resident sleeping room number 4. The window did open fully but required a push to open at the	0 800		

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0 800	Continued From page 45 top left corner along with the normal operation of the window crank handle. There was water damage at the bottom of the door jambs leading into the basement bathroom and laundry room. During a facility tour on July 10, 2024, at 11:40 a.m., LALD/CNS-C, and ULP-B, verified the above listed observations while accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in	0 810		

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0 810	Continued From page 46 their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop the fire safety and evacuation plan with required content, make the plan readily available, provide required training and drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On July 10, 2024, at 12:15 p.m., licensed assisted living director/ clinical nurse supervisor (LALD/CNS)-C, provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility.	0 810		

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0 810	Continued From page 47 FIRE SAFETY AND EVACUATION PLAN The licensee provided FSEP, failed to include the following: The location of resident sleeping rooms was not oriented accurately on the FSEP evacuation plan and both facility levels of the evacuation plan were included on the same plan making it confusing and unclear of direction and location of resident rooms. The evacuation plan is required to be posted in a conspicuous location in the common areas of each level of the facility and accurately include the location of resident rooms and floor plan of the facility. It was also observed there were no numbers on or adjacent to the resident rooms matching the evacuation plan. Room numbers are required to be installed on or adjacent to the resident rooms to provide direction to the occupants in the event of a fire or similar emergency. The FSEP did not identify specific fire protection actions for residents as evident by not providing procedures for resident in the event of a fire or similar emergency in writing in the plan. During an interview on July 10, 2024, at 12:25 p.m., LALD/CNS-C, stated the evacuation floor plan did not accurately indicate location of resident rooms, numbers were not installed on resident room doors and resident procedures in the event of a fire were not available in writing in the plan. TRAINING Record review indicated the licensee failed to provide training to employees on the FSEP upon	0 810		

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0 810	Continued From page 48 hire and at least twice per year as evident by not providing documentation the required employee training was completed. Record review indicated the licensee failed to provided evacuation training to residents at least once per year as evident by not providing documentation training was provided annually to the residents. During an interview on July 10, 2024, at 12:30 p.m., LALD/CNS-C, stated documentation was not available for staff or resident training requirements. DRILLS Record review indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month as evident providing documentation evacuation drills were conducted in February and April of 2024 only. During an interview on July 10, 2024, at 12:45 p.m., LALD/CNS-C, stated the only documentation available for evacuation drills conducted was for February and April of 2024. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 820 SS=G	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	0 820		

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0 820	Continued From page 49 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 failed to provide facilities that were not a distinct hazard to life. This had the potential to directly affect a limited number of residents and staff. 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). Findings include: On a facility tour on July 10, 2024, at 12:00 p.m. with licensed assisted living director/ clinical nurse supervisor (LALD/CNS)-C and unlicensed personnel (ULP)-B, it was observed that compliant emergency escape and rescue openings were not provided in resident sleeping room number 2. Occupied Resident Rooms	0 820	This immediate correction order identified on July 10, 2024, has had the immediacy lifted as of July 11, 2024, however non-compliance remained a scope and level of G.	

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0 820	Continued From page 50 Resident sleeping room number 2, occupied by R2, emergency escape and rescue clear window opening measurements are 32.25 inches wide, 19.5 inches in height, and 629 square inches in openable area. The window was measured with LALD/CNS-C, ULP-B, and survey staff present. The window did not meet the minimum requirements for clear opening height and openable clear area. Existing emergency escape and rescue openings are required to meet a minimum clear opening area of 648 square inches and have a minimum dimension of 20 inches in height and a minimum dimension of 20 inches in width. Windowsill height shall not be more than 48 inches from the floor to the clear opening. These deficient conditions were visually verified by LALD/CNS-C, and ULP-B, accompanying on the tour. Survey staff explained that an immediate correction order was issued for the above findings. TIME PERIOD FOR CORRECTION: Immediate	0 820		
01500 SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the	01500		

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	36648	A. BUILDING: _____ B. WING _____	07/11/2024

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01500	Continued From page 51 exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology	01500		

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01500	Continued From page 52 that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employees received at least eight (8) hours of training for each 12 months of employment for one of one employee (registered nurse (RN)-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: RN-D was hired to the licensee on March 23, 2020, to provide direct oversite to unlicensed personnel (ULP) and to provide direct care to residents. RN-D's employee record included three hours of orientation to home care completed on March 20, 2020, and four hours of orientation to assisted living on February 19, 2024. RN-D's employee record lacked training in 2021, 2022, and 2023. In addition, RN-D lacked four hours of annual training to meet the requirement of eight hours of annual training every twelve months for 2024. On July 9, 2024, at 9:16 a.m., the surveyor	01500		

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01500	Continued From page 53 observed the licensee's employee list. The surveyor observed three employees' not including RN-D who had a start date prior to February 2023. On July 9, 2024, at 10:18 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C the licensee provided annual training at an annual in person meeting. LALD/CNS-C stated since the licensure they did not have the annual meeting because they had a resident for a short period of time in June of 2023 and then did not have any more residents at the assisted living facility until February of 2024. LALD/CNS-C stated during that time they did not provide education because no one was working at the facility. The surveyor inquired if they were still employed. LALD/CNS-C stated yes. LALD/CNS-C stated they planned on restarting the meeting again because the assisted living facility had residents. The licensee's Staff Orientation and Education policy dated February 3, 2023, indicated all staff who provided assisted living services would complete at least eight hours of education for every 12 months of employment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		
01530 SS=F	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at	01530		

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01530	Continued From page 54 least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure direct-care staff received at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date for two of two direct care employees (unlicensed personnel (ULP)-A, 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected	01530		

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01530	Continued From page 55 or has the potential to affect a large portion or all of the residents). The findings include: ULP-A ULP-A was hired on February 20, 2024, to provide direct cares and services to residents. ULP-A's employee record lacked eight hours of initial dementia care training on topics specified under paragraph (b) within 160 working hours of the employment start date. On July 9, 2024, at 10:31 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated ULP-A was a full-time employee who worked 40 or more hours per week. ULP-B ULP-B was hired on February 23, 2024, to provide direct cares and services to residents. ULP-B's employee record lacked eight hours of initial dementia care training on topics specified under paragraph (b) within 160 working hours of the employment start date. On July 9, 2024, at 10:24 a.m., LALD/CNS-C stated they did not provide any dementia care training including initial or annual training to any staff members because they thought it was a requirement only if the licensee held an assisted living with dementia licensure. The licensee's Dementia Education policy dated February 3, 2023, indicated direct care employees must have completed at least eight hours of initial dementia education within 160	01530		

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01530	Continued From page 56 working hours of employment start date. Supervisors of direct-care staff would have at least eight hours of initial dementia education within 120 working hours of employment start date. Until the employee's completed the required eight hours of dementia care training they were not able to provide direct care unless there was another employee onsite who had completed the initial eight-hour training. In addition, all employees would complete at least two hours of education related to dementia care for each 12 months of employment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident	01620		

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01620	Continued From page 57 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 observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing resident monitoring and reassessment to include all areas required on the uniform assessment tool per Minnesota Rule 4659.0150 for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 admitted to the licensee on February 20, 2024, and began receiving assisted living services. R1's service plan signed February 20, 2024, indicated R1 received assistance with housekeeping, transportation, laundry, meals, medication administration, vital signs monthly, behavior management, and activity of daily living reminders.	01620		

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01620	Continued From page 58 On July 9, 2024, at 8:39 a.m., the surveyor observed unlicensed personnel administer Vitamin D3 1000 units (u), metformin extended release (ER) 500 milligrams (mg), and olanzapine 20 mg to R1. R1's 14-day reassessment and ongoing assessments titled Nurse Reassessment Visit dated March 2, 2024, March 9, 2024, May 1, 2024, and May 28, 2024, lacked areas required on the uniform assessment tool including: - activities of daily living, including dressing, grooming, bathing, and personal hygiene; - eating, dental status, oral care, and assistive devices and dentures, if applicable; - instrumental activities of daily living including housework, laundry, and transportation; - physical health status, including: -a review of relevant health history and current health conditions, including medical and nursing diagnoses; -allergies and sensitivities related to medication, seasonality, environment, and food and if any of the allergies or sensitivities are life threatening; - smoking, including the ability to smoke without causing burns or injury to the resident or others or damage to property; and - alcohol and drug use, including the resident's alcohol use or drug use not prescribed by a physician. On July 9, 2024, at 2:34 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated they used the document titled Nurse Reassessment Visit for 14-day assessments, 90-day assessments, and change of condition assessments. LALD/CNS-C believed the document met the requirement because it was provided to the licensee by a home care	01620		

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01620	Continued From page 59 consultant. The surveyor reviewed the uniform assessment tool with LALD/CNS-C. LALD/CNS-C stated they did not know the items addressed on the uniform assessment tool had to be addressed with each assessment. The licensee's Comprehensive Nursing Assessment policy dated February 3, 2023, indicated the registered nurse (RN) would conduct a comprehensive assessment utilizing a uniform assessment tool that addressed the following: "a. Head to Toe Evaluation i. Current Medical and Nursing Diagnoses/Health Conditions ii. Communication and Sensory Capabilities 1. Hearing 2. Vision 3. Speech 4. Assistive Communication and Sensory Devices, including a. Hearing Aids b. The Ability to Understand and be Understood iii. Activities of Daily Living iv. Instrumental Activities of Daily Living v. Skin/Integument Status vi. Digestive/Nutritional Status, including 1. Hydration 2. Diet 3. Food Allergies 4. Weight vii. Respiratory Status 1. Seasonal Allergies viii. Urinary Status ix. Joint/Muscle Status x. Endocrine xi. Cardiovascular, including 1. Vital Signs xii. Neurological Status	01620		

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01620	Continued From page 60 xiii. Pain, including 1. Location, Frequency, Intensity and Duration 2. Effectiveness of Medications and Nonmedication Interventions xiv. Infectious Conditions xv. Mental/Emotional Health, including 1. Cognition, including a. Review of Neurocognitive Evaluations and Diagnoses b. Current Memory, Orientation, Confusion and Decision-Making Status and Ability 2. History/Diagnoses of Mood Disorders, such as a. Depression, b. Anxiety c. Bipolar Disorder d. Thought or Behavioral Disorders 3. Current Symptoms of Mental Health Conditions and Behavioral Expressions of Concern 4. Effective Medication Treatment and Nonmedication Interventions xvi. Psychological Status, including Losses xvii. Lifestyle Preferences, including 1. Social Supports/Needs 2. Sleep schedule 3. Leisure Activities 4. Prior Housing Situation(s) 5. Smoking, including Safety Factors 6. Alcohol/Drug Use (nonprescribed) xviii. Spiritual Assessment xixi. Cultural Assessment xx. Safety Factors xxi. Health History, including: 1. Access of Health Care over Past 12 Months, including a. Medical Visits (PCP) b. Hospitalizations	01620		

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01620	Continued From page 61 c. Surgeries d. Post-Acute In-Patient Care e. Dental Visits f. Emergency Room Visits 2. Reports from Physical Therapy, Occupational Therapy, Speech Therapy or Cognitive Evaluations within Past 12 Months b. Vulnerability Assessment, including Risk for Elopement c. Falls Risk Assessment d. SLUMS (if appropriate) e. Nutritional Assessment (if appropriate) f. Medications* i. Medication Allergies g. Emergency Information, including Evacuation Level** h. End of Life Preferences, including i. Health Care Directives ii. "DNR/DNI" orders iii. POLST" No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication	01730		

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01730	Continued From page 62 management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and maintain a current individualized medication management record for each resident to include all required content for three of three residents (R1, R2, R3).	01730		

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01730	Continued From page 63 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 R1 admitted to the licensee on February 20, 2024, and began receiving assisted living services. R1's service plan signed February 20, 2024, indicated R1 received assistance with housekeeping, transportation, laundry, meals, medication administration, vital signs monthly, behavior management, and activity of daily living reminders. On July 9, 2024, at 8:39 a.m., the surveyor observed unlicensed personnel administer Vitamin D3 1000 units (u), metformin extended release (ER) 500 milligrams (mg), and olanzapine 20 mg to R1. R1's Medication Administration Record dated July 1, 2024, included metformin 500 mg once daily, omeprazole 20 mg delayed release (DR) once daily, Vitamin "3D" (sic) 1000 u once daily, and olanzapine 20 mg once daily at bedtime. R1's undated Home Health Aide Care Plan indicated R1 did not like to take their medication and R1 took medication when given to him. Staff were to place medication in R1's hand and	01730		

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01730	Continued From page 64 remind them what their medication was for, and make sure R1 took the medication. R1's Medication Management Plan completed February 20, 2024, indicated R1 needed assistance with medication set up, medication administration, medication education, cleaning support, monitoring of supplies and refills of medications, storage, and security of medications by having check marks next to all of the items listed above however, did not have additional information. In addition, when to notify a registered nurse (RN) was left blank on the form. R1's medication management plan comprised of multiple documents lacked the following required content: - a statement describing the medication management services that will be provided; - a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; - identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; - identification of medication management tasks that may be delegated to unlicensed personnel; and - procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services. R2 R2 admitted the licensee on February 20, 2024, and began receiving assisted living services. R2's service plan dated February 20, 2024, indicated R2 received assistance with medication	01730		

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	36648	A. BUILDING: _____ B. WING _____	07/11/2024

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01730	Continued From page 65 management, monthly vital signs, housekeeping, transportation, and meals. R2's Medication Administration Record dated July 1, 2024, included aripiprazole solution 1 mg/milliliter (ml) take 20 mg by mouth daily. R2's Home Health Aide Care Plan dated February 20, 2024, indicated R2 needed assistance with medication set up and administration. R2 would need monitoring and a reminder to take or self-administer medications. R2 had a history of checking pills, holding liquids going into a bathroom and spitting the medication out. Administer R2's medications at breakfast. R2's Medication Management Plan dated February 20, 2024, indicated R2 received medication set up by a pharmacy monthly, medications were administered by ULP or RN, medication education was provided by the RN as needed (PRN), cleaning support was completed by the ULP daily, monitoring of supplies and refills was complete by the RN daily, storage of medications was completed by the ULP or RN daily, and staff were to notify a RN with any side effects or refusals of medication. R2's medication management plan comprised of multiple documents lacked the following required content: -a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; and - identification of medication management tasks that may be delegated to unlicensed personnel. R3 R3 admitted to the licensee on April 19, 2024,	01730		

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01730	Continued From page 66 and began receiving assisted living services. R3's service plan signed April 19, 2024, indicated R3 received assistance with activity of daily living reminders, meals, medication administration, vital signs monthly, behavior management, housekeeping, transportation, and laundry. On July 8, 2024, at approximately 9:32 a.m., during a facility tour the surveyor observed one bottle of Taurine 500 mg, one bottle of C-1000, one bottle of milk thistle extract 300 mg, one bottle of vitamin B3 niacin 300 mg, one bottle of E-400 mg, one bottle of CoQ10 30 mg, one bottle of L-Tyrosine 500 mg, one bottle of L- Lysine 500 mg, one bottle of iron 15 mg, one bottle of B-6 100 mg, one bottle of astaxanthin 4 mg, one bottle of NAC 600 mg, one bottle of nettle 900 mg, one bottle of omega 3 fish oil 1000 mg, one bottle of melatonin 10 mg, and one bottle of minoxidil 2.5 mg in R3's room. R3's Medication Administration Record dated July 1, 2024, included divalproex sodium delayed release 250 mg at bedtime and olanzapine 20 mg at bedtime. R3's prescriber orders signed April 23, 2024, included Depakote 250 mg at bedtime, olanzapine 20 mg at bedtime, dutasteride 0.5 mg daily, Zyrtec 10 mg as needed (PRN) daily, and Flonase nasal spray 50 micrograms (mcg) PRN daily. The licensee lacked discontinuation orders for dutasteride 0.5, Zyrtec 10 mg, and Flonase nasal spray. The surveyor observed the fax sent by the licensee to the provider related to the over-the-counter medications. The prescriber responded on June 18, 2024, by signing the	01730		

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01730	Continued From page 67 bottom of the list of OTC medications and on a separate page wrote "Okay to take his OTC medication dutasteride and minoxidil." R3's Home Health Aide Care Plan date April 19, 2024, indicated R3 did not like to take their medication and R3 took medication when given to him. Staff were to place medication in R3's hand and remind them what their medication was for. R3's Medication Management Plan dated April 19, 2024, indicated R3 received medication set up by a pharmacy monthly, medications were administered by ULP or RN, medication education was provided by the RN as needed (PRN), cleaning support was completed by the ULP daily, monitoring of supplies and refills was complete by the RN daily, storage of medications was completed by the ULP or RN daily, and staff were to notify a RN with any side effects or refusals of medication. R3's medication management plan comprised of multiple documents lacked the following required content: - an accurate statement describing the medication management services that will be provided; - an accurate description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; and - identification of medication management tasks that may be delegated to unlicensed personnel. On July 9, 2024, at 8:24 a.m., R3 stated all of the vitamins were theirs however, they do not take them all. On July 9, 2024, at 11:22 a.m., LALD/CNS-C	01730		

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01730	Continued From page 68 stated they believed they had filled in all the areas of the assessment however, they did not for R1. LALD/CNS-C stated they also believed they wrote what tasks could be delegated to a ULP for all residents however, they were unable to find any documentation of this. On July 10, 2024, at 8:09 a.m., LALD/CNS-C stated they made a list of all the medication R3 self-administered and faxed the list to the provider. LALD/CNS-C stated R3's medication management plan did not accurately show what medications were being given by the licensee and where each medication was stored. The licensee's Service Plan for Medication Management policy dated July 13, 2019, read, "1. The written Medication Management Plan includes the following provisions. a. A statement describing the medication management services to be provided b. A description of the storage of medications based on the client assessment * and addressing i. Client preference ii. Risk of diversion iii. Instructions per manufacturer c. Documentation procedures d. Procedures for verifying the prescription medications are administered as prescribed e. Procedures for medication reconciliation* f. Identification of person(s) responsible for monitoring medication supplies and ensuring refills are ordered/timely g. Description of medication management tasks to be delegated to unlicensed personnel h. Plans for notifying licensed health professional when/if a problem with medication management services arises."	01730		

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01730	Continued From page 69 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01760 SS=F	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to accurately document the time medications were administered for two of two residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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).	01760		

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01760	Continued From page 70 The findings include: R1 R1 admitted to the licensee on February 20, 2024, and began receiving assisted living services. R1's service plan signed February 20, 2024, indicated R1 received assistance with housekeeping, transportation, laundry, meals, medication administration, vital signs monthly, behavior management, and activity of daily living reminders. R1's After Visit Summary dated April 17, 2024, included Vitamin D3 1000 u daily, metformin extended release (ER) 500 mg once daily, olanzapine 20 mg at bedtime, and omeprazole 20 mg by mouth daily. The After Visit Summary lacked a prescriber signature. R1's Medication Administration Record dated July 1, 2024, included metformin 500 mg once daily in the morning, omeprazole 20 mg delayed release (DR) once daily in the morning, Vitamin "3D" (sic) 1000 u once daily in the morning, and olanzapine 20 mg once daily at bedtime. On July 9, 2024, at 8:39 a.m., the surveyor observed unlicensed personnel (ULP)-B administer Vitamin D3 1000 units (u), metformin extended release (ER) 500 milligrams (mg), and olanzapine 20 mg to R1. ULP-B asked if they wanted their omeprazole in the evening. R1 stated they wanted their omeprazole in the evening. On July 9, 2024, at 9:00 a.m., licensed assisted living director/clinical nurse supervisor	01760		

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01760	Continued From page 71 (LALD/CNS)-C stated R1 was able to choose the time of omeprazole because it was a once-a-day medication. The surveyor showed LALD/CNS-C the medication administration record that indicated omeprazole would be administered in the a.m. LALD/CNS-C stated the ULP would sign the MAR once given in the evening. R2 R2 admitted the licensee on February 20, 2024, and began receiving assisted living services. R2's service plan dated February 20, 2024, indicated R2 received assistance with medication management, monthly vital signs, housekeeping, transportation, and meals. R2's Medication Administration Record dated July 1, 2024, included aripiprazole solution 1 mg/milliliter (ml) take 20 mg by mouth daily in the morning. R2's prescriber order's signed April 16, 2024, indicated no primary care prescriptions and psychiatric medication to be administered per psychiatry. R2's chart lacked psychiatry prescribers orders. On July 9, 2024, from 7:32 a.m. to 7:49 a.m., the surveyor observed R2 awake for the day, eat cereal, and exit the facility to attend work. The surveyor did not observe R2 take any medication. On July 9, 2024, at 12:14 p.m., the surveyor received R2 paper MAR and observed R2 had one scheduled medication for the morning. The surveyor did not observe the medication documented on as administered. On June 10, 2024, at 8:36 a.m., LALD/CNS-C	01760		

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01760	Continued From page 72 stated all residents were allowed to choose the time they took their medication if it was a daily medication. LALD/CNS-C stated residents frequently changed their minds of when they wished to receive the medication. LALD/CNS-C stated when the medication was administered the ULP would initial the MAR. The surveyor inquired if they had documentation if a medication was given after the time listed on the MAR for all residents. LALD/CNS-C stated no. LALD/CNS-C stated the pharmacy labeled what time the medications should be administered. The surveyor inquired if they had spoken to resident's health care providers about timing of the medications (medication doses given too close or too far apart and potential side effects). LALD/CNS-C stated no they had not spoken to the prescribers. The licensee's Medication Documentation policy dated July 13, 2019, indicated each medication administered by the licensee's staff would be documented accurately and legibly. Complete documentation of medication administration included the following: - clients [residents] name; - medication name; - medication dosage; - date and time of administration; - method and route of administration; and - initials of staff administering medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01820 SS=E	144G.71 Subd. 13 Prescriptions	01820		

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	36648	A. BUILDING: _____ B. WING _____	07/11/2024

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01820	Continued From page 73 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 ensure written or electronically recorded prescriptions were obtained for two of three residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at 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: R1 R1 admitted to the licensee on February 20, 2024, and began receiving assisted living services. R1's service plan signed February 20, 2024, indicated R1 received assistance with housekeeping, transportation, laundry, meals, medication administration, vital signs monthly, behavior management, and activity of daily living reminders. On July 9, 2024, at 8:39 a.m., the surveyor observed unlicensed personnel administer	01820		

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01820	Continued From page 74 Vitamin D3 1000 units (u), metformin extended release (ER) 500 milligrams (mg), and olanzapine 20 mg to R1. R1's Medication Administration Record dated July 1, 2024, included metformin 500 mg once daily, omeprazole 20 mg delayed release (DR) once daily, Vitamin "3D" [sic] 1000 u once daily, and olanzapine 20 mg once daily at bedtime. R1's After Visit Summary dated April 17, 2024, included Vitamin D3 1000 u daily, metformin extended release (ER) 500 mg once daily, olanzapine 20 mg at bedtime, and omeprazole 20 mg by mouth daily. The After Visit Summary lacked a prescriber signature. On July 9, 2024, at 11:11 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated they believed the After Visit Summary counted for prescriber's orders. LALD/CNS-C stated they did not realize there was no prescriber signature. R2 R2 admitted the licensee on February 20, 2024, and began receiving assisted living services. R2's service plan dated February 20, 2024, indicated R2 received assistance with medication management, monthly vital signs, housekeeping, transportation, and meals. R2's Medication Administration Record dated July 1, 2024, included aripiprazole solution 1 mg/milliliter (ml) take 20 mg by mouth daily. R2's prescriber's orders signed April 16, 2024, indicated no primary care prescriptions and psych medication to be administered per psychiatry.	01820		

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	36648	A. BUILDING: _____ B. WING _____	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01820	Continued From page 75 R2's chart lacked psychiatry prescribers orders. On July 9, 2024, at 12:10 p.m., LALD/CNS-C stated they did not have signed provider orders for R2 and the medication they administered were from R2's psychiatrist. The licensee's Prescriber Orders policy dated February 3, 2023, indicated written orders from an authorized prescriber would be obtained for all medications and treatment with which the assisted living assists residents, including over the counter medication. No further information was 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 prescription medications were securely locked in a substantially constructed compartment and permitted only authorized personnel to have access. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	01880		

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01880	Continued From page 76 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 July 8, 2024, at 9:25 a.m., the surveyor entered the licensee's facility with unlicensed personnel (ULP)-A and visitor (V)-E. R1 was in their room for an unknown period time without staff members in the facility. ULP-A stayed near the surveyor while V-E sat on the living room couch. On July 8, 2024, at 9:32 a.m., the surveyor began to tour the facility. ULP-A assisted the surveyor in showing them the kitchen and the outdoor refrigerator located in the detached garage. When the surveyor reentered the facility after observing the garage, the surveyor opened a closet door located near the front door and living room, next to a dining room table. The surveyor observed R1, R2, and R3's medication bins and five medical charts belonging to residents and home care clients. The surveyor inquired why the closet door was not locked. ULP-A stated, "I didn't want to waste my time." the door was "stuck", and they were unable to get it to lock. ULP-A stated they were late for transporting two residents to work and were going to fix it when they returned however, the surveyor was at the facility. On July 8, 2024, at approximately 10:21 a.m., during the entrance conference licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated the closet that contained medications and medical records should be	01880		

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01880	Continued From page 77 locked when staff members were not present. LALD/CNS-C stated ULP were trained to keep the closet door locked. The licensee's Storage / Control of Medications policy dated July 13, 2019, indicated all prescription drugs were securely locked in substantially constructed compartments according to the manufacturer's instructions and only authorized personnel have access to the stored medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to discard expired medication for one of three residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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
01890	Continued From page 78 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: R2 admitted the licensee on February 20, 2024, and began receiving assisted living services. R2's service plan dated February 20, 2024, indicated R2 received assistance with medication management, monthly vital signs, housekeeping, transportation, and meals. On July 8, 2024, at approximately 9:32 a.m., during a facility tour, the surveyor observed a medication closet and observed the following medications expired: - R2 had 1 card of benztropine with an expiration date of May 8, 2023. ULP-A stated they had never seen R2 take the medication listed above and they believed R2 only took the medication when R2 experienced allergy symptoms. R2's medical record lacked an order for the medication listed above. On July 8, 2024, at 11:21 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated expired meds were disposed of through the licensee's pharmacy. LALD/CNS-C stated expired medication should not be located in the medication closet. LALD/CNS-C stated they kept the medication listed above because it was as needed (PRN) for tremors and R2 never requested the medication so they never ordered a new medication from pharmacy when it expired.	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36648	A. BUILDING: _____ B. WING _____	07/11/2024

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01890	Continued From page 79 The licensee's Disposition / Disposal of Medication policy dated July 13, 2019, indicated discontinued medication may be kept until the expiration dates if there is a possibility of resuming the medication. If not resumed before the expiration date it will be disposed of according to this policy. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
02320 SS=D	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure unlicensed personnel (ULP)-B followed appropriate medication administration procedures for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or	02320		

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02320	Continued From page 80 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-B was hired on February 20, 2024, to provide direct cares and services to residents. ULP-B's employee record indicated ULP-B received a medication competency evaluation on February 23, 2024. On July 8, 2024, at 10:21 a.m., during the entrance conference, licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated ULP were trained and completed a competency evaluation prior to administering medication. LALD/CNS-C stated ULP were trained to compare the medication card against the medication administration record (MAR). R1's service plan signed February 20, 2024, indicated R1 received assistance with housekeeping, transportation, laundry, meals, medication administration, vital signs monthly, behavior management, and activity of daily living reminders. R1's Medication Administration Record dated July 1, 2024, included metformin 500 milligrams (mg) once daily in the morning, omeprazole 20 mg delayed release (DR) once daily in the morning, Vitamin "3D" (sic) 1000 units (u) once daily in the morning, and olanzapine 20 mg once daily at bedtime. R1's Medication Protocol for Oral Medications signed February 20, 2024, indicated ULP were to check the medication profile for right person, right day, right time, count the number of pills for the	02320		

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02320	Continued From page 81 day and check for additional instructions. Then ULP were to check the medication box for the right person, right day, right time and right number of pills for the day and time prior to medication administration. On July 9, 2024, at 8:39 a.m., the surveyor observed ULP-B remove the medication from the medication closet, remove Vitamin D3 1000 u, metformin extended release (ER) 500 mg, and olanzapine 20 mg from R1's medication card and place in the medication cup. ULP-B asked if R1 wanted their omeprazole in the evening. R1 stated they wanted their omeprazole in the evening. ULP-B then administered the medication listed above to R1. The surveyor did not observe a medication count or verification of orders prior to administration. ULP-B stated they were trained on medication administration by LALD/CNS-C. The surveyor inquired how they knew which medication to administer to R1. ULP-B stated, "it is on the prescription label. I studied their medication administration too." The surveyor inquired how ULP-B knew there was no medication changes. ULP-B stated, " I was sure it did not change cause [sic] every day I do this." The licensee's Medication Administration policy dated July 13, 2019, indicated clients [residents] were entitled to the safe administration of medications by qualified personnel according to a written medication management plan. All staff with responsibility for medication administration have access to information about the medication being administered including but not limited to: - purpose; - dosage; - route; - frequency; - instructions related to the medication and	02320		

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02320	Continued From page 82 specific to the clients [residents], as appropriate; - side effects; and - clients [residents] allergies to medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		

Electronically Delivered

August 6, 2024

Licensee
Total Home Health Services LLC
6949 Idaho Avenue North
Brooklyn Park, MN 55428

RE: Project Number(s) SL36648015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 11, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

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

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

fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

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

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

St - 0 - 0470 - 144g.41 Subdivision 1 - Minimum Requirements - $3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $3,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a

hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. to submit a hearing request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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

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

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

If you have any questions, please contact me.

Sincerely,

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

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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: SL36648015-0 On July 8, 2024, through July 11, 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 three residents all of whom received services under the provider's Assisted Living Facility license. An immediate correction order was identified on July 9, 2024, issued for SL36648015-0, tag identification 0470. On July 10, 2024, the immediacy of correction order 0470 was removed, however non-compliance remained, and the scope and level remained unchanged. An immediate correction order was identified on July 10, 2024, issued for SL36648015 tag	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	

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0 000	Continued From page 1 identification 0820. On July 11, 2024, the immediacy of correction order 0820 was removed, however non-compliance remained, and the scope and level remained unchanged	0 000		
0 110 SS=C	144G.10 Subdivision 1a Assisted living director license required Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the licensed assisted living director (LALD) was listed as the Director of Record for the licensee. This had the potential to affect all the licensee's residents, staff, and visitors. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). These findings include: On July 8, 2024, at 7:41a.m. and 10:17 a.m., the surveyor observed the Board of Executives for Long-Term Services and Supports (BELTSS)	0 110		

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0 110	Continued From page 2 website which indicated licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C held a current assisted living director license, however, was not listed as the director of record for the licensee. On July 8, 2024, at 10:21 a.m., LALD/CNS-C stated they were not aware they needed to be listed as the director of record on BELTSS. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 110		
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	0 250		

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0 250	Continued From page 3 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 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 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	0 250		

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0 250	Continued From page 4 developed and/or implemented current policies and procedures as required with records reviewed. 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 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 July 8, 2024, at 10:21 a.m., licensed assisted living director/clinical nurse supervisor (LALD/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 four and five 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.	0 250		

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0 250	Continued From page 5 - 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 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.	0 250		

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0 250	Continued From page 6 sect. 144.051 Data Relating to Licensed and Registered Persons (opens in a new window), all data submitted on this application shall be 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 six was electronically signed by LALD/CNS-C on July 1, 2023. The licensee had an assisted living license issued on September 1, 2023, with an expiration date of August 31, 2024.	0 250		

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	36648	A. BUILDING: _____ B. WING _____	07/11/2024

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0 250	Continued From page 7 The licensee failed to ensure the following policies and procedures were developed and/or implemented: - orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; - 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; - 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; - medication management; and - delegation of tasks by registered nurses or licensed health professionals. On July 10, 2024, at approximately 9:09 a.m., LALD/CNS-C confirmed the licensee provided assisted living services but failed to implement corresponding policies and procedures, as required. As a result of this survey, the following orders were issued 0110, 0460, 0470, 0480, 0485, 0550, 0580, 0650, 0660, 0680, 0700, 0780, 0790, 0800, 0810, 0820, 1500, 1530, 1620, 1730, 1760, 1820, 1880, 1890, and 2320 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	0 250		

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0 250	Continued From page 8 (21) days	0 250		
0 460 SS=F	144G.41 Subdivision 1 Minimum requirements (5) provide a means for residents to request assistance for health and safety needs 24 hours per day, seven days per week; (6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract; (7) permit residents access to food at any time; (8) allow residents to choose the resident's visitors and times of visits; (9) allow the resident the right to choose a roommate if sharing a unit; (10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living facility must not lock a resident in the resident's unit; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide a means for residents to request assistance for health and safety needs 24 hours a day, seven days a week. This 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	0 460		

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0 460	Continued From page 9 failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On July 8, 2024, from 9:32 a.m., to 10:07 a.m., during a facility tour, the surveyor observed a two-level home and did not observe call lights, call pendants, or bells located in the rooms of the residents or in the common areas. On July 8, 2024, at 10:28 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated they did not provide means for the residents to request assistance for health and safety. LALD/CNS-C stated the licensee would have a system to request assistance "if they [staff] were distanced from the client [resident] but as you can see the staff is right here. They just call out and we are able to hear. The person in the basement is real stable. They [residents] are all stable and aware." LALD/CNS-C stated residents were physically able to come ask for assistance, and they believed the licensee had bells, however, did not place with the residents because they thought the bells were not needed. The surveyor inquired if the residents had been offered the call bell. LALD/CNS-C stated no. LALD/CNS-C stated they would locate the bells and place them in the resident's rooms. On July 9, 2024, at 8:24 a.m., R3 stated they ambulated out of the room if they needed assistance or could yell however, they mainly came out of the room if they requested assistance. On July 10, 2024, at 7:41 a.m., the surveyor inquired how R2 requested assistance. R2 stated,	0 460		

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0 460	Continued From page 10 "I don't want to answer that question." From July 8, 2024, to July 10, 2024, the surveyor did not see bells within the assisted living facility. The licensee's Staffing policy dated February 3, 2023, indicated residents were provided with a means to request assistance for health and safety needs 24 hours per day seven days per week. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 460		
0 470 SS=G	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster 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	0 470		

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0 470	Continued From page 11 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 that one or more persons were 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. This impacted one of three residents (R1) who received care from the licensee. 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: R1 admitted to the licensee on February 20, 2024, and began receiving assisted living services. R1 resided in the lower level of the facility. R1's diagnosis included schizophrenia (mental disorder characterized by delusions, hallucinations, disorganized thoughts, speech, and behavior).	0 470		

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0 470	Continued From page 12 R1's service plan signed February 20, 2024, indicated R1 received assistance with medication administration, meals, behavior management, and reminders for activities of daily living. On July 8, 2024, at 8:53 a.m., the surveyor arrived at the licensee's facility and observed no cars in the driveway, no cars in the garage, and no human activity through the windows on the upper level of the facility. The surveyor continued to ring the doorbell, knock on the door, and call the licensee with no response until 9:20 a.m. On July 8, 2024, at 9:20 a.m., a white Equinox pulled into the driveway. The surveyor observed unlicensed personnel (ULP)-A and visitor (V)-E exit the vehicle. ULP-A stated V-E had a flat tire, and their boss would pick V-E up from the facility. The surveyor inquired if the facility had active residents. ULP-A stated they had three residents with similar working hours and all three were at work. The surveyor inquired if all three were at work right now. ULP-A stated they took two to work however, one was at their grandparent's house for the weekend and the grandparent would drop them off later at the facility. On July 8, 2024, from 9:32 a.m. to 10:10 a.m., the surveyor observed a two-level facility. The surveyor first observed the first level of the facility. There were no residents in the rooms. At approximately 10:06 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C arrived at the facility. At 10:07 a.m., LALD/CNS-C stated there was a bedroom in the basement to observe however, the resident arrived at the facility when the surveyor was touring another resident room. The surveyor walked down the staircase to the lower level and knocked on R1's	0 470		

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0 470	Continued From page 13 door. R1 stated they were sleeping and did not want to be interrupted with a tour or interview. On July 8, 2024, at 11:15 a.m., LALD/CNS-C stated they had two residents who worked at the same time and staff transported them together, so no one was left unattended at the facility. LALD/CNS-C stated R1 was not in the house this morning that is why they were able to drop off the other two residents. LALD/CNS-C stated residents were not to be left in the house unattended. On July 9, 2024, at 6:51 a.m., ULP-A stated if R1 did not work and the other two residents needed to be transported to work, they would have R1 ride with them. ULP-A stated R1 liked to pick up McDonalds for breakfast on days they did not work and R1 worked on Friday and Saturdays. On July 9, 2024, at 6:53 a.m., the surveyor observed ULP-B enter the facility. On July 9, 2024, at 7:32 a.m., R2 stated staff were present when they were at the facility. On July 9, 2024, at 7:39 a.m., R1 stated they worked at a restaurant and went to their grandparents home every two weeks. The surveyor inquired when they returned to the facility. R1 stated Sunday. The survey inquired what they did yesterday morning. R1 stated "I was not up remember you tried knocking on my door." R1 stated he did not leave the facility on June 8, 2024. On July 9, 2024, the surveyor observed R1, and R2 exit the facility with ULP-A. R3 was in the room sleeping and ULP-B was attending to other tasks in the facility.	0 470		

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0 470	Continued From page 14 On July 9, 2024, at 7:49 a.m., ULP-B stated they work every Monday, Tuesday, Thursday, and Friday morning so the other ULP could transport residents to their jobs. The surveyor inquired why they were not here on July 8, 2024. ULP-B stated they had a dental appointment, and their understanding was R1 was not at the house. On July 9, 2024, at 7:52 a.m., grandparent (GP)-F stated they did not want to be interviewed until R1 was on the phone with the surveyor. On July 9, 2024, at 8:24 a.m., R3 stated the other two resident did not come with them every time to get dropped off or pick up from work however, other residents would come in the car at times so they could go to the store. R3 stated they were left alone once where they had to call an ambulance because there was no one able to assist them at the facility. On July 9, 2024, at 8:39 a.m., ULP-A and R1 returned to the facility. ULP-A than left the facility again. On July 9, 2024, at 8:51 a.m., GP-F stated they dropped off R1 at the facility at 1:30 p.m. on July 7th, 2024. On July 9, 2024, at 11:28 a.m., LALD/CNS-C stated R1 was their own person and knew how to evacuate the house in case of an emergency. LALD/CNS-C stated there was supposed to be a sign in and out sheet the resident used to keep track of where they were located. The surveyor asked to see the document. LALD/CNS-C stated they were unable to locate the document. LALD/CNS-C stated staff should be looking at the sheets to see who was in the facility and who was	0 470		

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0 470	Continued From page 15 out for the day. LALD/CNS-C stated staff were suppose to wait at the facility until another staff member arrived if they needed to transport a resident. The surveyor inquired again if LALD/CNS-C saw R1 walk into the facility. LALD/CNS-C stated when they entered the facility, they saw R1 in the staircase leading to the basement they assumed R1 had been dropped off by their grandparents. LALD/CNS-C stated another staff member said it was ok for ULP-B not to come to the facility when they were suppose to. On July 9, 2024, at 1:49 p.m., the surveyor attempted to contact ULP-A via phone for an interview. There was no answer, and the surveyor was unable to leave a voice message. The licensee's Incident Report Log included an incident on June 1, 2024, that indicated staff left a resident unattended at the facility and the licensee trained staff not to leave residents unattended. The licensee's Incident Report dated June 1, 2024, indicated R3 was left unattended at the facility when they believed they had urinated out a parasite. R3 attempted to call for staff's help however, staff were not present. R3 than called 911 and staff arrived back at the facility after law enforcement arrived on the scene. The action that was taken read "staff were talked to -to never lave residents unattended for any reason w/out informing the supervisor, manager, or a nurse. Wait for other staff to get here." The licensee's undated staffing plan indicated the licensee's had three scheduled shifts which included 7:00 a.m. to 5:00 p.m., 3:00 p.m., to 11:00 p.m., and 11:00 p.m. to 9:00 a.m. The	0 470		

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0 470	Continued From page 16 schedule indicated there were overlapping staff coverage between the hours of 7:00 am to 9:00 a.m., and 3:00 p.m. to 5:00 p.m. where there were two staff present at the facility. The licensee's Staffing policy dated February 3, 2023, indicated residents were provided with a means to request assistance for health and safety needs 24 hours per day seven days per week and the ULP would respond to resident requests for assistance as soon as possible. In addition, the clinical nurse supervisor (CNS) would prepare and implement a 24-hour daily staffing plan that ensured adequate staffing to meet the resident needs at all times including reasonably and foreseeable needs. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE In addition, the licensee failed to develop and implement a written staffing plan that included an evaluation completed by the clinical nurse supervisor (CNS) (as indicated in Minnesota Administrative Rule 4659.0180) at least twice a year. This had the potential to affect all residents, staff, and visitors. The findings include: The licensee held an assisted living license. The facility was licensed for a capacity of three residents. On July 9, 2024, at 12:36 p.m., LALD/CNS-C provided the surveyor with the licensee's staffing plan. The licensee's undated staffing plan indicated the licensee's had three scheduled shifts which included 7:00 a.m. to 5:00 p.m., 3:00	0 470		

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0 470	Continued From page 17 p.m., to 11:00 p.m., and 11:00 p.m. to 9:00 a.m. The schedule indicated there was overlapping staff coverage between the hours of 7:00 a.m. to 9:00 a.m., and 3:00 p.m. to 5:00 p.m. where there were two staff present at the facility. The staffing plan lacked an evaluation conducted by the CNS, to be conducted at least twice a year. LALD/CNS-C stated they reviewed the staffing plan however, they did not write a date. The licensee's Staffing policy dated February 3, 2023, indicated the CNS would prepare and implement a 24-hour daily staffing plan that ensured adequate staffing to meet residents' needs at all times, including reasonably foreseeable needs. No further information was provided.	0 470		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according 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	0 480		

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0 480	Continued From page 18 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 July 8, 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		
0 485 SS=F	144G.41 Subdivision 1. (13)(i)(A)and(C) Minimum Requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (A) menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes; and (C) the facility cannot require a resident to include and pay for meals in their contract; (ii) weekly housekeeping; (iii) weekly laundry service;	0 485		

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0 485	Continued From page 19 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure at least three nutritious meals daily were served according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 R1 admitted to the licensee on February 20, 2024, and began receiving assisted living services. R1's service plan signed February 20, 2024, indicated R1 received assistance with housekeeping, transportation, laundry, meals, medication administration, vital signs monthly, behavior management, and activity of daily living reminders. R2 R2 admitted the licensee on February 20, 2024, and began receiving assisted living services. R2 service plan dated February 20, 2024,	0 485		

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	36648	A. BUILDING: _____ B. WING _____	07/11/2024

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0 485	Continued From page 20 indicated R2 received assistance with medication management, monthly vital signs, housekeeping, transportation, and meals. R3 R3 admitted to the licensee on April 19, 2024, and began receiving assisted living services. R3's service plan signed April 19, 2024, indicated R3 received assistance with activity of daily living reminders, meals, medication administration, vital signs monthly, behavior management, housekeeping, transportation, and laundry. On July 8, 2024, during a facility tour at 9:32 a.m., the surveyor observed an undated Weekly Menu posted on the licensee's refrigerator in the kitchen. Unlicensed personnel (ULP)-A stated they always had bananas and apples available for the residents. The surveyor observed two apples left in the fruit basket. ULP-A stated the licensee received new fruit every Monday. The surveyor observed the licensee's indoor and outdoor refrigerators and cabinets and observed the following food items, turkey lunch meat-two containers, hot peppers, garlic, yogurt, milk, meatless spaghetti sauces, breads including buns, pop, apple juice, coconut, condiments, frozen shrimp, frozen hamburger patties, fish sticks, pizzas, French fries, macaroni and cheese, penne noodles, pancake mix, spices, cereal boxes, oatmeal, peanut butter, frozen chicken breasts, and water. The menu included seven days, Monday through Sunday and included breakfast, lunch, dinner, and two snacks. The menu included the following meals and snacks: - snack Monday through Sunday twice per day was "animal crackers, apply (sic) or banana"; - Thursday breakfast: oatmeal, milk, banana, or	0 485		

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0 485	Continued From page 21 cereal with milk; - Sunday breakfast: waffle with banana and milk; - Monday lunch: spaghetti with spaghetti sauce, lettuce, juice; - Wednesday lunch: macaroni with spaghetti sauce, lettuce, with drink; - Tuesday dinner: pizza with mixed vegetable; - Wednesday dinner: pancake with milk and fruits; - Friday dinner: waffle with milk and fruits; - Saturday dinner: macaroni and cheese with lettuce and juice; and - Sunday dinner: pizza with vegetable and juice. In addition, eggs were listed on the menu for breakfast on Monday, Tuesday, Wednesday, Saturday. The surveyor did not see the following food items listed on the menu: -animal crackers; - lettuce; -eggs; and -mixed vegetables either frozen or fresh. The menu lacked a date of service and lacked a protein source. The menus lacked at least three nutritious meals daily according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines. On July 8, 2024, at 1:47 p.m., licensed assisted living director/clinical nurse supervisor stated they posted a menu however, they thought the menu could just list the days of the week. LALD/CNS-C stated fruit was always available on site. LALD/CNS-C stated they did provide meal substitutions that included hot dog, hamburger, macaroni and cheese, pizza, and lunch meat. The surveyor reviewed the menu with LALD/CNS-C. LALD/CNS-C stated for breakfast	0 485		

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0 485	Continued From page 22 residents could choose turkey lunch meat, hot dog or breakfast sausages to add for protein. The surveyor stated to LALD/CNS-C they did not observe sausages or hot dogs for the residents. LALD/CNS-C stated, "they must have ran (sic) out." In addition, LALD/CNS-C stated they were unsure why the menu lacked a protein source. On July 8, 2024, the surveyor did not observe lunch offered or made. There was one resident in the facility over the lunch hour. On July 9, 2024, at 7:32 a.m., the surveyor observed R2 pour and consume a bowl of cereal and milk. On July 9, 2024, at 8:24 a.m., R3 stated for breakfast they received waffles, cereal, or oatmeal. The surveyor inquired if they received breakfast sausages, breakfast sandwiches, or hot dogs. R2 stated no. The surveyor listed out multiple protein sources to R2 and inquired if they received any of the protein sources for lunch or dinner. R3 stated they received a protein source sometimes at lunch and dinner. R3 stated they always had apples or bananas in the facility. On July 9, 2024, at 8:39 a.m., the surveyor observed R1 return to the facility with McDonalds for breakfast. On July 9, 2024, the surveyor did not observe staff offer R1 a lunch. R1 remained in their room after they ate McDonalds. On July 10, 2024, at 7:40 a.m., the surveyor observed R2 eating cereal with milk and a staff member cooked oatmeal. On July 10, 2024, at 9:09 a.m., LALD/CNS-C	0 485		

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0 485	Continued From page 23 stated the residents were independent and had the choice of what they ate. LALD/CNS-C stated the residents worked and had money and could purchase other items. LALD/CNS-C stated the licensee provided groceries and the residents were involved with grocery shopping. The USDA titled My Plate Dietary Guidelines for Americans dated 2020- 2025, recommended men between 19 to 59 years old should receive six to seven ounces equivalent towards their daily recommended amount of protein. The licensee's Food Service policy dated February 3, 2023, indicated meals were prepared according to the recommended dietary allowances in the USDA guidelines including seasonal fresh fruit and fresh vegetables. In addition, menus were prepared one week in advance and made available to all residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting	0 550		

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0 550	Continued From page 24 suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post required information related to the licensee's grievance procedure to include contact information for the Office of Ombudsman for Long-Term Care (OOLTC) and Mental Health and Developmental Disabilities (OOMHDD). 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 client'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 July 8, 2024, at 9:32 a.m., during facility tour, the surveyor observed there was no evidence of the contact information for the state and applicable regional OOLTC and OOMHDD. On July 8, 2023, at 10:55 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C verified they licensee did not post the contact information for OOLTC or OOMHDD.	0 550		

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0 550	Continued From page 25 LALD/CNS-C stated the thought they had posted the required information however; it was not posted. The licensee's Grievance policy dated February 3, 2024, read, "2. A copy of the grievance procedure is conspicuously posted in the residence with the following information: o Name, phone number and email contact information for the individuals who are responsible for handling resident complaints o Contact information for the state and any regional Office of Ombudsman for Long-Term-Care o Contact information for the Office of Ombudsman for Mental Health and Developmental Disabilities o Contact information for the Minnesota Adult Abuse Reporting Center o Contact information for the Minnesota Department of Health, Office of Health Facility Complaints if an individual has a complaint about the facility or person providing services." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to	0 580		

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0 580	Continued From page 26 be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to implement and maintain a quality management program (QMP) appropriate to the size of the facility and relevant to the type of services provided. This had the potential to affect all residents, staff, and visitors. 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 July 8, 2024, at approximately 10:16 a.m., during the entrance conference, licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated they licensee did not have a quality management program because the current residents admitted after February of 2024. LALD/CNS-C stated they did not have one prior due to not having residents for a prolonged period of time. On July 10, 2024, at 8:12 a.m., LALD/CNS-C stated prior to the three current residents, there	0 580		

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0 580	Continued From page 27 last resident they provided services to was in June of 2023. The licensee's Quality Improvement policy dated July 13, 2019, indicated the licensee had established a quality improvement program based on the agency size and appropriate to its medication management program in order to assure that effective, comprehensive, and appropriate plans were operational for all medication management clients within the organization. In addition, documentation of the organization's quality improvement program was to be maintained for at least two years and would be provided to the commissioner at the time of survey, investigation or renewal as requested. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 580		
0 650 SS=F	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;	0 650		

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0 650	Continued From page 28 (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 the employee record contained the required content for three of three employees (unlicensed personnel (ULP-A, ULP-B, registered nurse (RN)-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 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 ULP-A was hired on February 20, 2024, to provide direct cares and services to residents. ULP-A's employee record lacked the following content: - current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; - training on the following:	0 650		

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0 650	Continued From page 29 - prevention of falls for providers working with elderly or individuals at risk of falls; and - communication skill include preserving the dignity of the resident and show respect for the resident and the residents preferences, cultural background, and family. - competencies evaluations on the following: - range of motion and positioning; - safe transfer techniques and ambulation; - stand by assistance techniques and how to perform them; and - appropriate and safe techniques in personal hygiene and grooming including hair care, bathing, care of teeth, gums and oral prosthetic devices, care and use of hearing aides, and dressing and assisting with toileting. - training and competency evaluation on unplanned times away from home. ULP-A's employee record included areas to document the training and competency evaluations listed above with the exception of unplanned time away however, they were marked not applicable. ULP-B ULP-B was hired on February 23, 2024, to provide direct cares and services to residents. ULP-B's employee record lacked the following content: - current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; - training on the following: - prevention of falls for providers working with elderly or individuals at risk of falls; and - communication skill include preserving the dignity of the resident and show respect for the resident and the residents preferences, cultural	0 650		

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0 650	Continued From page 30 background, and family. - competencies evaluations on the following: - range of motion and positioning; - safe transfer techniques and ambulation; - stand by assistance techniques and how to perform them; and - appropriate and safe techniques in personal hygiene and grooming including hair care, bathing, care of teeth, gums and oral prosthetic devices, care and use of hearing aides, and dressing and assisting with toileting. - training and competency evaluation on unplanned times away from home. ULP-B's record included areas to document the training and competency evaluations listed above with the exception of unplanned time away however, they were marked not applicable. On July 10, 2024, at 7:44 a.m. ULP-B stated they were trained and passed the competency evaluations listed above however, the current residents did not require that assistance. RN-D RN-D was hired to the licensee on March 23, 2020, to provide direct oversite to unlicensed personnel (ULP) and to provide direct care to residents. RN-D's employee record lacked the following required content: - current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; and - documentation of annual performance reviews that identify areas of improvement needed and training needs. On July 9, 2024, at 10:18 a.m., licensed assisted	0 650		

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0 650	Continued From page 31 living director/clinical nurse supervisor (LALD/CNS)-C stated they believed ULP-A, ULP-B, and RN-A took their job description home with them. On July 9, 2024, at 10:37 a.m., LALD/CNC-C stated they trained and completed competency evaluations for all of the topics listed above however, they did not have documentation of it. LALD/CNS-C stated they put not applicable on the trainings and competency evaluations because the residents at the facility did not require those skills. On July 9, 2024, at 10:40 a.m., LALD/CNS-C stated they trained and completed competency evaluation for unplanned time away from home however, had no documentation in the employee record. The licensee's Personnel Records dated February 3, 2023, read, "2. At a minimum, all documents related to the following are kept in the personnel record, as applicable to job requirements o Evidence of current professional licensure, registration or certification o Results of background studies o Records of annual training and infection control training o Documentation of orientation o Documentation of supervision, as applicable o Performance reviews o Competency evaluations o Signed job description o Documentation of annual performance reviews identifying areas of improvement needed and training needs". No further information was provided.	0 650		

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0 650	Continued From page 32 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 660 SS=E	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 maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), which included a two-step tuberculin skin test (TST) or other evidence of TB screening such as a blood test for two of three employees (unlicensed personnel (ULP)-A, 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	0 660		

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0 660	Continued From page 33 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: The facility TB risk assessment form dated June 24, 2024, indicated the facility was at a low risk for TB transmission. ULP-A ULP-A was hired on February 20, 2024, to provide direct cares and services to residents. ULP-A's employee record included a health history and symptom screening completed on February 20, 2024. The document had a section for the two-step TST however, was left uncompleted. ULP-B ULP-B was hired on February 23, 2024, to provide direct cares and services to residents. ULP-B's employee record included a health history and symptom screening completed on February 23, 2024. The document had a section for the two-step TST however, was left uncompleted. ULP-A and ULP-B's records lacked a two-step tuberculin skin test (TST) or other evidence of TB screening such as a blood test. On July 9, 2024, at 10:37 a.m., licensed assisted living director/clinical nurse supervisor	0 660		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36648	A. BUILDING: _____ B. WING _____	07/11/2024

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0 660	Continued From page 34 (LALD/CNS)-C verified ULP-A's employee record lacked TB screening. LALD/CNS-C stated they asked ULP-A to provide one to them however, ULP-A did not bring one in. LALD/CNS-C stated once they filed the new hire paperwork, they forgot to follow up with ULP-A on receiving the TB screen. On July 9, 2024, at 10:57 a.m., the surveyor inquired if ULP-B completed a TB screening. LALD/CNS-C verified ULP-B lacked a TB screening. LALD/CNS-C stated, "I don't know why. She is supposed to have one in the record." The CDC's document titled Baseline Tuberculosis Screening and Testing for Health Care Personnel dated December 19, 2023, recommended all United States health care personnel should be screened for TB upon hire. This process should include risk assessment, symptom evaluation, and TB blood test or TB skin test. The licensee's Tuberculosis Screening/Prevention policy dated February 3, 2023, indicated the licensee would observe the recommended precautions related to TB prevention as identified by the CDC and the Minnesota Department of Health (MDH). No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements:	0 680		

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0 680	Continued From page 35 (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. 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	0 680		

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0 680	Continued From page 36 a large portion or all of the residents). The findings include: The licensee's emergency disaster preparedness plan lacked evidence of the following required content: - annual update; - hazard vulnerability risk assessment; - quarterly review of missing resident policy; - emergency plan (EP) program patient population to include transportation and staff who would assume specific roles in another's absence; - polices and procedures for evacuation to include transportation, alternate evacuation location; - arrangement with other facilities; - contact names and information; - emergency officials contact information to include state licensing and certification agency; and - emergency prep testing requirements. On July 10, 2024, at 8:36 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated the licensee's EPP was created in January of 2022 and was reviewed annually in January. LALD/CNS-C stated they did not document when the EPP was reviewed or created. LALD/CNS-C stated they reviewed the missing resident policy yearly and was unaware of the requirement to review the policy quarterly. LALD/CNS-C stated they would use their own vehicles for transportation however, they did not document this in the EPP. LALD/CNS-C stated the primary evacuation location was a backyard of a neighbor, they did not have an alternative site, and they did not have written arrangements with other facilities.	0 680		

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0 680	Continued From page 37 The licensee's Emergency Preparedness policy dated February 3, 2023, indicated the licensee would have an identified plan in place to assure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupts services. In addition, a disaster drill would be conducted at the residence at least annually and the results of the drill would be documented. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 700 SS=F	144G.43 Subdivision 1 Resident record (b) Resident records, whether written or electronic, must be protected against loss, tampering, or unauthorized disclosure in compliance with chapter 13 and other applicable relevant federal and state laws. The facility shall establish and implement written procedures to control use, storage, and security of resident records and establish criteria for release of resident information. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure personal health and medical information was kept private for two of three residents (R1, R3) and three home care clients (C4, C5, C6). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	0 700		

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0 700	Continued From page 38 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). These finding include: On July 8, 2024, at 9:25 a.m., the surveyor entered the licensee's facility with unlicensed personnel (ULP)-A and visitor (V)-E. R1 was in their room for an unknown period time without staff members in the facility. ULP-A stayed near the surveyor while V-E sat on the living room couch. On July 8, 2024, at 9:32 a.m., the surveyor began to tour the facility. ULP-A assisted the surveyor in showing them the kitchen and the outdoor refrigerator located in the detached garage. When the surveyor reentered the facility after observing the garage, the surveyor opened a closet door located near the front door and living room, next to a dining room table. The surveyor observed R1, R3, C4, C5, and C6's full medical records and R1, R2, and R3's medications. The surveyor inquired why the closet door was not locked. ULP-A stated, "I didn't want to waste my time." the door was "stuck", and they were unable to get the door to lock. ULP-A stated they were late for transporting two residents to work and were going to fix it when they returned however, the surveyor was at the facility. On July 8, 2024, at approximately 10:21 a.m., during the entrance conference. Licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated the closet that contained medications and medical records should be locked when staff members were not present.	0 700		

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	36648	A. BUILDING: _____ B. WING _____	07/11/2024

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0 700	Continued From page 39 LALD/CNS-C stated ULP were trained to keep the closet door locked. The licensee's Privacy of Protected Health Information policy dated February 3, 2023, indicated the licensee shall protect the privacy of its resident's personal health information. In addition, no clinical records or personal health information about residents would be accessible in public areas. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 700		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and	0 780		

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0 780	Continued From page 40 (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide interconnected smoke alarms and a smoke alarm outside in the immediate vicinity of all sleeping rooms throughout the facility. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). Findings include: Interconnection On a facility tour on July 10, 2024, at 11:45 a.m., with licensed assisted living director/ clinical nurse supervisor (LALD/CNS)-C, and unlicensed personnel (ULP)-B, it was observed that smoke alarms were not interconnected so activation of one alarm activates all alarms throughout the facility. During the tour the alarms were tested and alarmed individually but there were no alarms interconnected so activation of one alarm activates alarms throughout the facility. All dwelling units required to have multiple smoke	0 780		

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0 780	Continued From page 41 alarms are required to have interconnected alarms so activation of one alarm activates all alarms within the dwelling unit. During the tour the smoke alarms were tested and LALD/CNS-C, and ULP-B, verified the smoke alarms were not interconnected so activation of one alarm activates all alarms throughout the facility. Outside Sleeping Rooms On the same tour it was also observed that smoke alarms were not provided outside in the immediate vicinity of sleeping room number 4 in the lower level. There was a smoke alarm in the lower level, but it was located remotely away from the outside of resident room number 4. Smoke alarms are required to be installed outside in the immediate vicinity of all sleeping rooms. During the tour LALD/CNS-C, and ULP-B, verified smoke alarms were not installed outside in the immediate vicinity of resident room number 4 in the lower level of the facility. TIME PERIOD FOR CORRECTION: Two (2) days	0 780		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code,	0 790		

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0 790	Continued From page 42 located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide or maintain fire extinguishers as required throughout the facility. This deficient condition had the ability to affect all staff, visitors, and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) 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 a facility tour on July 10, 2024, at 12:10 p.m., with licensed assisted living director/ clinical nurse supervisor (LALD/CNS)-C, and unlicensed personnel (ULP)-B, it was observed that the required fire extinguisher was located under the kitchen sink cabinet with no sign indicating the location of the extinguisher. The provided extinguisher was still in the manufacture packaging, was not mounted at least 4 inches off the floor, and had a date of manufacture of 2022 with no documentation of annual maintenance or monthly inspections. At least one fire extinguisher with minimum	0 790		

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0 790	Continued From page 43 2-A:10-B:C rating is required to be provided, mounted, maintained, and located within 75 feet of travel throughout the facility. Fire extinguishers are required to be mounted at least 4 inches off the floor and not higher than 60 inches from the floor to the top of the extinguisher. Documentation is required to demonstrate fire extinguishers have been inspected by facility personnel monthly, and annually replaced with a new extinguisher (of current year manufacture date) or serviced by a certified technician. During interview on July 10, 2024, at 12:15 p.m., LALD/CNS-C, and ULP-B, verified this deficient finding. TIME PERIOD FOR CORRECTION: Two (2) days	0 790		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and	0 800		

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0 800	Continued From page 44 well-being of the residents. 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). Findings include: On a facility tour on July 10, 2024, at 11:30 a.m., with licensed assisted living director/ clinical nurse supervisor (LALD/CNS)-C, and unlicensed personnel (ULP)-B, the surveyor made the following observations of facility disrepair: The door seal on the strike side door jamb was coming off and not sealing the door from the weather. The screen and storm window were falling out of the storm window/ screen frame on the outside of the window in resident sleeping room number 1. The light switch cover was in need of repair in the main floor bathroom. There was moisture damage from water on the ceiling in the shower of the main floor bathroom. The top left corner of the emergency escape and rescue window was sticky and hard to open in resident sleeping room number 4. The window did open fully but required a push to open at the top left corner along with the normal operation of	0 800		

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0 800	Continued From page 45 the window crank handle. There was water damage at the bottom of the door jambs leading into the basement bathroom and laundry room. During a facility tour on July 10, 2024, at 11:40 a.m., LALD/CNS-C, and ULP-B, verified the above listed observations while accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the	0 810		

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0 810	Continued From page 46 proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop the fire safety and evacuation plan with required content, make the plan readily available, provide required training and drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On July 10, 2024, at 12:15 p.m., licensed assisted living director/ clinical nurse supervisor (LALD/CNS)-C, provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN	0 810		

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0 810	Continued From page 47 The licensee provided FSEP, failed to include the following: The location of resident sleeping rooms was not oriented accurately on the FSEP evacuation plan and both facility levels of the evacuation plan were included on the same plan making it confusing and unclear of direction and location of resident rooms. The evacuation plan is required to be posted in a conspicuous location in the common areas of each level of the facility and accurately include the location of resident rooms and floor plan of the facility. It was also observed there were no numbers on or adjacent to the resident rooms matching the evacuation plan. Room numbers are required to be installed on or adjacent to the resident rooms to provide direction to the occupants in the event of a fire or similar emergency. The FSEP did not identify specific fire protection actions for residents as evident by not providing procedures for resident in the event of a fire or similar emergency in writing in the plan. During an interview on July 10, 2024, at 12:25 p.m., LALD/CNS-C, stated the evacuation floor plan did not accurately indicate location of resident rooms, numbers were not installed on resident room doors and resident procedures in the event of a fire were not available in writing in the plan. TRAINING Record review indicated the licensee failed to provide training to employees on the FSEP upon hire and at least twice per year as evident by not	0 810		

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	36648	A. BUILDING: _____ B. WING _____	07/11/2024

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0 810	Continued From page 48 providing documentation the required employee training was completed. Record review indicated the licensee failed to provided evacuation training to residents at least once per year as evident by not providing documentation training was provided annually to the residents. During an interview on July 10, 2024, at 12:30 p.m., LALD/CNS-C, stated documentation was not available for staff or resident training requirements. DRILLS Record review indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month as evident providing documentation evacuation drills were conducted in February and April of 2024 only. During an interview on July 10, 2024, at 12:45 p.m., LALD/CNS-C, stated the only documentation available for evacuation drills conducted was for February and April of 2024. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 820 SS=G	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	0 820		

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0 820	Continued From page 49 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 failed to provide facilities that were not a distinct hazard to life. This had the potential to directly affect a limited number of residents and staff. 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). Findings include: On a facility tour on July 10, 2024, at 12:00 p.m. with licensed assisted living director/ clinical nurse supervisor (LALD/CNS)-C and unlicensed personnel (ULP)-B, it was observed that compliant emergency escape and rescue openings were not provided in resident sleeping room number 2. Occupied Resident Rooms Resident sleeping room number 2, occupied by	0 820	This immediate correction order identified on July 10, 2024, has had the immediacy lifted as of July 11, 2024, however non-compliance remained a scope and level of G.	

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0 820	Continued From page 50 R2, emergency escape and rescue clear window opening measurements are 32.25 inches wide, 19.5 inches in height, and 629 square inches in openable area. The window was measured with LALD/CNS-C, ULP-B, and survey staff present. The window did not meet the minimum requirements for clear opening height and openable clear area. Existing emergency escape and rescue openings are required to meet a minimum clear opening area of 648 square inches and have a minimum dimension of 20 inches in height and a minimum dimension of 20 inches in width. Windowsill height shall not be more than 48 inches from the floor to the clear opening. These deficient conditions were visually verified by LALD/CNS-C, and ULP-B, accompanying on the tour. Survey staff explained that an immediate correction order was issued for the above findings. TIME PERIOD FOR CORRECTION: Immediate	0 820		
01500 SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights;	01500		

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01500	Continued From page 51 (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and	01500		

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01500	Continued From page 52 involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employees received at least eight (8) hours of training for each 12 months of employment for one of one employee (registered nurse (RN)-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: RN-D was hired to the licensee on March 23, 2020, to provide direct oversite to unlicensed personnel (ULP) and to provide direct care to residents. RN-D's employee record included three hours of orientation to home care completed on March 20, 2020, and four hours of orientation to assisted living on February 19, 2024. RN-D's employee record lacked training in 2021, 2022, and 2023. In addition, RN-D lacked four hours of annual training to meet the requirement of eight hours of annual training every twelve months for 2024. On July 9, 2024, at 9:16 a.m., the surveyor observed the licensee's employee list. The	01500		

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01500	Continued From page 53 surveyor observed three employees' not including RN-D who had a start date prior to February 2023. On July 9, 2024, at 10:18 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C the licensee provided annual training at an annual in person meeting. LALD/CNS-C stated since the licensure they did not have the annual meeting because they had a resident for a short period of time in June of 2023 and then did not have any more residents at the assisted living facility until February of 2024. LALD/CNS-C stated during that time they did not provide education because no one was working at the facility. The surveyor inquired if they were still employed. LALD/CNS-C stated yes. LALD/CNS-C stated they planned on restarting the meeting again because the assisted living facility had residents. The licensee's Staff Orientation and Education policy dated February 3, 2023, indicated all staff who provided assisted living services would complete at least eight hours of education for every 12 months of employment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		
01530 SS=F	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics	01530		

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01530	Continued From page 54 specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure direct-care staff received at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date for two of two direct care employees (unlicensed personnel (ULP)-A, 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) 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	01530		

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01530	Continued From page 55 of the residents). The findings include: ULP-A ULP-A was hired on February 20, 2024, to provide direct cares and services to residents. ULP-A's employee record lacked eight hours of initial dementia care training on topics specified under paragraph (b) within 160 working hours of the employment start date. On July 9, 2024, at 10:31 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated ULP-A was a full-time employee who worked 40 or more hours per week. ULP-B ULP-B was hired on February 23, 2024, to provide direct cares and services to residents. ULP-B's employee record lacked eight hours of initial dementia care training on topics specified under paragraph (b) within 160 working hours of the employment start date. On July 9, 2024, at 10:24 a.m., LALD/CNS-C stated they did not provide any dementia care training including initial or annual training to any staff members because they thought it was a requirement only if the licensee held an assisted living with dementia licensure. The licensee's Dementia Education policy dated February 3, 2023, indicated direct care employees must have completed at least eight hours of initial dementia education within 160 working hours of employment start date.	01530		

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01530	Continued From page 56 Supervisors of direct-care staff would have at least eight hours of initial dementia education within 120 working hours of employment start date. Until the employee's completed the required eight hours of dementia care training they were not able to provide direct care unless there was another employee onsite who had completed the initial eight-hour training. In addition, all employees would complete at least two hours of education related to dementia care for each 12 months of employment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for	01620		

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01620	Continued From page 57 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 observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing resident monitoring and reassessment to include all areas required on the uniform assessment tool per Minnesota Rule 4659.0150 for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 admitted to the licensee on February 20, 2024, and began receiving assisted living services. R1's service plan signed February 20, 2024, indicated R1 received assistance with housekeeping, transportation, laundry, meals, medication administration, vital signs monthly, behavior management, and activity of daily living reminders. On July 9, 2024, at 8:39 a.m., the surveyor	01620		

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01620	Continued From page 58 observed unlicensed personnel administer Vitamin D3 1000 units (u), metformin extended release (ER) 500 milligrams (mg), and olanzapine 20 mg to R1. R1's 14-day reassessment and ongoing assessments titled Nurse Reassessment Visit dated March 2, 2024, March 9, 2024, May 1, 2024, and May 28, 2024, lacked areas required on the uniform assessment tool including: - activities of daily living, including dressing, grooming, bathing, and personal hygiene; - eating, dental status, oral care, and assistive devices and dentures, if applicable; - instrumental activities of daily living including housework, laundry, and transportation; - physical health status, including: -a review of relevant health history and current health conditions, including medical and nursing diagnoses; -allergies and sensitivities related to medication, seasonality, environment, and food and if any of the allergies or sensitivities are life threatening; - smoking, including the ability to smoke without causing burns or injury to the resident or others or damage to property; and - alcohol and drug use, including the resident's alcohol use or drug use not prescribed by a physician. On July 9, 2024, at 2:34 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated they used the document titled Nurse Reassessment Visit for 14-day assessments, 90-day assessments, and change of condition assessments. LALD/CNS-C believed the document met the requirement because it was provided to the licensee by a home care consultant. The surveyor reviewed the uniform	01620		

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01620	Continued From page 59 assessment tool with LALD/CNS-C. LALD/CNS-C stated they did not know the items addressed on the uniform assessment tool had to be addressed with each assessment. The licensee's Comprehensive Nursing Assessment policy dated February 3, 2023, indicated the registered nurse (RN) would conduct a comprehensive assessment utilizing a uniform assessment tool that addressed the following: "a. Head to Toe Evaluation i. Current Medical and Nursing Diagnoses/Health Conditions ii. Communication and Sensory Capabilities 1. Hearing 2. Vision 3. Speech 4. Assistive Communication and Sensory Devices, including a. Hearing Aids b. The Ability to Understand and be Understood iii. Activities of Daily Living iv. Instrumental Activities of Daily Living v. Skin/Integument Status vi. Digestive/Nutritional Status, including 1. Hydration 2. Diet 3. Food Allergies 4. Weight vii. Respiratory Status 1. Seasonal Allergies viii. Urinary Status ix. Joint/Muscle Status x. Endocrine xi. Cardiovascular, including 1. Vital Signs xii. Neurological Status xiii. Pain, including	01620		

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01620	Continued From page 60 1. Location, Frequency, Intensity and Duration 2. Effectiveness of Medications and Nonmedication Interventions xiv. Infectious Conditions xv. Mental/Emotional Health, including 1. Cognition, including a. Review of Neurocognitive Evaluations and Diagnoses b. Current Memory, Orientation, Confusion and Decision-Making Status and Ability 2. History/Diagnoses of Mood Disorders, such as a. Depression, b. Anxiety c. Bipolar Disorder d. Thought or Behavioral Disorders 3. Current Symptoms of Mental Health Conditions and Behavioral Expressions of Concern 4. Effective Medication Treatment and Nonmedication Interventions xvi. Psychological Status, including Losses xvii. Lifestyle Preferences, including 1. Social Supports/Needs 2. Sleep schedule 3. Leisure Activities 4. Prior Housing Situation(s) 5. Smoking, including Safety Factors 6. Alcohol/Drug Use (nonprescribed) xviii. Spiritual Assessment xixi. Cultural Assessment xx. Safety Factors xxi. Health History, including: 1. Access of Health Care over Past 12 Months, including a. Medical Visits (PCP) b. Hospitalizations c. Surgeries	01620		

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01620	Continued From page 61 d. Post-Acute In-Patient Care e. Dental Visits f. Emergency Room Visits 2. Reports from Physical Therapy, Occupational Therapy, Speech Therapy or Cognitive Evaluations within Past 12 Months b. Vulnerability Assessment, including Risk for Elopement c. Falls Risk Assessment d. SLUMS (if appropriate) e. Nutritional Assessment (if appropriate) f. Medications* i. Medication Allergies g. Emergency Information, including Evacuation Level** h. End of Life Preferences, including i. Health Care Directives ii. "DNR/DNI" orders iii. POLST" No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided;	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36648	A. BUILDING: _____ B. WING _____	07/11/2024

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01730	Continued From page 62 (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and maintain a current individualized medication management record for each resident to include all required content for three of three residents (R1, R2, R3). This practice resulted in a level two violation (a	01730		

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01730	Continued From page 63 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 R1 admitted to the licensee on February 20, 2024, and began receiving assisted living services. R1's service plan signed February 20, 2024, indicated R1 received assistance with housekeeping, transportation, laundry, meals, medication administration, vital signs monthly, behavior management, and activity of daily living reminders. On July 9, 2024, at 8:39 a.m., the surveyor observed unlicensed personnel administer Vitamin D3 1000 units (u), metformin extended release (ER) 500 milligrams (mg), and olanzapine 20 mg to R1. R1's Medication Administration Record dated July 1, 2024, included metformin 500 mg once daily, omeprazole 20 mg delayed release (DR) once daily, Vitamin "3D" (sic) 1000 u once daily, and olanzapine 20 mg once daily at bedtime. R1's undated Home Health Aide Care Plan indicated R1 did not like to take their medication and R1 took medication when given to him. Staff were to place medication in R1's hand and remind them what their medication was for, and	01730		

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01730	Continued From page 64 make sure R1 took the medication. R1's Medication Management Plan completed February 20, 2024, indicated R1 needed assistance with medication set up, medication administration, medication education, cleaning support, monitoring of supplies and refills of medications, storage, and security of medications by having check marks next to all of the items listed above however, did not have additional information. In addition, when to notify a registered nurse (RN) was left blank on the form. R1's medication management plan comprised of multiple documents lacked the following required content: - a statement describing the medication management services that will be provided; - a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; - identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; - identification of medication management tasks that may be delegated to unlicensed personnel; and - procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services. R2 R2 admitted the licensee on February 20, 2024, and began receiving assisted living services. R2's service plan dated February 20, 2024, indicated R2 received assistance with medication management, monthly vital signs, housekeeping,	01730		

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01730	Continued From page 65 transportation, and meals. R2's Medication Administration Record dated July 1, 2024, included aripiprazole solution 1 mg/milliliter (ml) take 20 mg by mouth daily. R2's Home Health Aide Care Plan dated February 20, 2024, indicated R2 needed assistance with medication set up and administration. R2 would need monitoring and a reminder to take or self-administer medications. R2 had a history of checking pills, holding liquids going into a bathroom and spitting the medication out. Administer R2's medications at breakfast. R2's Medication Management Plan dated February 20, 2024, indicated R2 received medication set up by a pharmacy monthly, medications were administered by ULP or RN, medication education was provided by the RN as needed (PRN), cleaning support was completed by the ULP daily, monitoring of supplies and refills was complete by the RN daily, storage of medications was completed by the ULP or RN daily, and staff were to notify a RN with any side effects or refusals of medication. R2's medication management plan comprised of multiple documents lacked the following required content: -a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; and - identification of medication management tasks that may be delegated to unlicensed personnel. R3 R3 admitted to the licensee on April 19, 2024, and began receiving assisted living services.	01730		

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01730	Continued From page 66 R3's service plan signed April 19, 2024, indicated R3 received assistance with activity of daily living reminders, meals, medication administration, vital signs monthly, behavior management, housekeeping, transportation, and laundry. On July 8, 2024, at approximately 9:32 a.m., during a facility tour the surveyor observed one bottle of Taurine 500 mg, one bottle of C-1000, one bottle of milk thistle extract 300 mg, one bottle of vitamin B3 niacin 300 mg, one bottle of E-400 mg, one bottle of CoQ10 30 mg, one bottle of L-Tyrosine 500 mg, one bottle of L- Lysine 500 mg, one bottle of iron 15 mg, one bottle of B-6 100 mg, one bottle of astaxanthin 4 mg, one bottle of NAC 600 mg, one bottle of nettle 900 mg, one bottle of omega 3 fish oil 1000 mg, one bottle of melatonin 10 mg, and one bottle of minoxidil 2.5 mg in R3's room. R3's Medication Administration Record dated July 1, 2024, included divalproex sodium delayed release 250 mg at bedtime and olanzapine 20 mg at bedtime. R3's prescriber orders signed April 23, 2024, included Depakote 250 mg at bedtime, olanzapine 20 mg at bedtime, dutasteride 0.5 mg daily, Zyrtec 10 mg as needed (PRN) daily, and Flonase nasal spray 50 micrograms (mcg) PRN daily. The licensee lacked discontinuation orders for dutasteride 0.5, Zyrtec 10 mg, and Flonase nasal spray. The surveyor observed the fax sent by the licensee to the provider related to the over-the-counter medications. The prescriber responded on June 18, 2024, by signing the bottom of the list of OTC medications and on a	01730		

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01730	Continued From page 67 separate page wrote "Okay to take his OTC medication dutasteride and minoxidil." R3's Home Health Aide Care Plan date April 19, 2024, indicated R3 did not like to take their medication and R3 took medication when given to him. Staff were to place medication in R3's hand and remind them what their medication was for. R3's Medication Management Plan dated April 19, 2024, indicated R3 received medication set up by a pharmacy monthly, medications were administered by ULP or RN, medication education was provided by the RN as needed (PRN), cleaning support was completed by the ULP daily, monitoring of supplies and refills was complete by the RN daily, storage of medications was completed by the ULP or RN daily, and staff were to notify a RN with any side effects or refusals of medication. R3's medication management plan comprised of multiple documents lacked the following required content: - an accurate statement describing the medication management services that will be provided; - an accurate description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; and - identification of medication management tasks that may be delegated to unlicensed personnel. On July 9, 2024, at 8:24 a.m., R3 stated all of the vitamins were theirs however, they do not take them all. On July 9, 2024, at 11:22 a.m., LALD/CNS-C stated they believed they had filled in all the areas	01730		

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01730	Continued From page 68 of the assessment however, they did not for R1. LALD/CNS-C stated they also believed they wrote what tasks could be delegated to a ULP for all residents however, they were unable to find any documentation of this. On July 10, 2024, at 8:09 a.m., LALD/CNS-C stated they made a list of all the medication R3 self-administered and faxed the list to the provider. LALD/CNS-C stated R3's medication management plan did not accurately show what medications were being given by the licensee and where each medication was stored. The licensee's Service Plan for Medication Management policy dated July 13, 2019, read, "1. The written Medication Management Plan includes the following provisions. a. A statement describing the medication management services to be provided b. A description of the storage of medications based on the client assessment * and addressing i. Client preference ii. Risk of diversion iii. Instructions per manufacturer c. Documentation procedures d. Procedures for verifying the prescription medications are administered as prescribed e. Procedures for medication reconciliation* f. Identification of person(s) responsible for monitoring medication supplies and ensuring refills are ordered/timely g. Description of medication management tasks to be delegated to unlicensed personnel h. Plans for notifying licensed health professional when/if a problem with medication management services arises." No further information was provided.	01730		

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01730	Continued From page 69 TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01760 SS=F	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to accurately document the time medications were administered for two of two residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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).	01760		

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01760	Continued From page 70 The findings include: R1 R1 admitted to the licensee on February 20, 2024, and began receiving assisted living services. R1's service plan signed February 20, 2024, indicated R1 received assistance with housekeeping, transportation, laundry, meals, medication administration, vital signs monthly, behavior management, and activity of daily living reminders. R1's After Visit Summary dated April 17, 2024, included Vitamin D3 1000 u daily, metformin extended release (ER) 500 mg once daily, olanzapine 20 mg at bedtime, and omeprazole 20 mg by mouth daily. The After Visit Summary lacked a prescriber signature. R1's Medication Administration Record dated July 1, 2024, included metformin 500 mg once daily in the morning, omeprazole 20 mg delayed release (DR) once daily in the morning, Vitamin "3D" (sic) 1000 u once daily in the morning, and olanzapine 20 mg once daily at bedtime. On July 9, 2024, at 8:39 a.m., the surveyor observed unlicensed personnel (ULP)-B administer Vitamin D3 1000 units (u), metformin extended release (ER) 500 milligrams (mg), and olanzapine 20 mg to R1. ULP-B asked if they wanted their omeprazole in the evening. R1 stated they wanted their omeprazole in the evening. On July 9, 2024, at 9:00 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated R1 was able to choose the	01760		

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01760	Continued From page 71 time of omeprazole because it was a once-a-day medication. The surveyor showed LALD/CNS-C the medication administration record that indicated omeprazole would be administered in the a.m. LALD/CNS-C stated the ULP would sign the MAR once given in the evening. R2 R2 admitted the licensee on February 20, 2024, and began receiving assisted living services. R2's service plan dated February 20, 2024, indicated R2 received assistance with medication management, monthly vital signs, housekeeping, transportation, and meals. R2's Medication Administration Record dated July 1, 2024, included aripiprazole solution 1 mg/milliliter (ml) take 20 mg by mouth daily in the morning. R2's prescriber order's signed April 16, 2024, indicated no primary care prescriptions and psychiatric medication to be administered per psychiatry. R2's chart lacked psychiatry prescribers orders. On July 9, 2024, from 7:32 a.m. to 7:49 a.m., the surveyor observed R2 awake for the day, eat cereal, and exit the facility to attend work. The surveyor did not observe R2 take any medication. On July 9, 2024, at 12:14 p.m., the surveyor received R2 paper MAR and observed R2 had one scheduled medication for the morning. The surveyor did not observe the medication documented on as administered. On June 10, 2024, at 8:36 a.m., LALD/CNS-C stated all residents were allowed to choose the	01760		

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01760	Continued From page 72 time they took their medication if it was a daily medication. LALD/CNS-C stated residents frequently changed their minds of when they wished to receive the medication. LALD/CNS-C stated when the medication was administered the ULP would initial the MAR. The surveyor inquired if they had documentation if a medication was given after the time listed on the MAR for all residents. LALD/CNS-C stated no. LALD/CNS-C stated the pharmacy labeled what time the medications should be administered. The surveyor inquired if they had spoken to resident's health care providers about timing of the medications (medication doses given too close or too far apart and potential side effects). LALD/CNS-C stated no they had not spoken to the prescribers. The licensee's Medication Documentation policy dated July 13, 2019, indicated each medication administered by the licensee's staff would be documented accurately and legibly. Complete documentation of medication administration included the following: - clients [residents] name; - medication name; - medication dosage; - date and time of administration; - method and route of administration; and - initials of staff administering medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01820 SS=E	144G.71 Subd. 13 Prescriptions There must be a current written or electronically	01820		

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01820	Continued From page 73 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 ensure written or electronically recorded prescriptions were obtained for two of three residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at 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: R1 R1 admitted to the licensee on February 20, 2024, and began receiving assisted living services. R1's service plan signed February 20, 2024, indicated R1 received assistance with housekeeping, transportation, laundry, meals, medication administration, vital signs monthly, behavior management, and activity of daily living reminders. On July 9, 2024, at 8:39 a.m., the surveyor observed unlicensed personnel administer Vitamin D3 1000 units (u), metformin extended	01820		

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01820	Continued From page 74 release (ER) 500 milligrams (mg), and olanzapine 20 mg to R1. R1's Medication Administration Record dated July 1, 2024, included metformin 500 mg once daily, omeprazole 20 mg delayed release (DR) once daily, Vitamin "3D" [sic] 1000 u once daily, and olanzapine 20 mg once daily at bedtime. R1's After Visit Summary dated April 17, 2024, included Vitamin D3 1000 u daily, metformin extended release (ER) 500 mg once daily, olanzapine 20 mg at bedtime, and omeprazole 20 mg by mouth daily. The After Visit Summary lacked a prescriber signature. On July 9, 2024, at 11:11 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated they believed the After Visit Summary counted for prescriber's orders. LALD/CNS-C stated they did not realize there was no prescriber signature. R2 R2 admitted the licensee on February 20, 2024, and began receiving assisted living services. R2's service plan dated February 20, 2024, indicated R2 received assistance with medication management, monthly vital signs, housekeeping, transportation, and meals. R2's Medication Administration Record dated July 1, 2024, included aripiprazole solution 1 mg/milliliter (ml) take 20 mg by mouth daily. R2's prescriber's orders signed April 16, 2024, indicated no primary care prescriptions and psych medication to be administered per psychiatry. R2's chart lacked psychiatry prescribers orders.	01820		

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01820	Continued From page 75 On July 9, 2024, at 12:10 p.m., LALD/CNS-C stated they did not have signed provider orders for R2 and the medication they administered were from R2's psychiatrist. The licensee's Prescriber Orders policy dated February 3, 2023, indicated written orders from an authorized prescriber would be obtained for all medications and treatment with which the assisted living assists residents, including over the counter medication. No further information was 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 prescription medications were securely locked in a substantially constructed compartment and permitted only authorized personnel to have access. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36648	A. BUILDING: _____ B. WING _____	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOTAL HOME HEALTH SERVICES LLC	6949 IDAHO AVENUE NORTH BROOKLYN PARK, MN 55428

(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
01880	Continued From page 76 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 July 8, 2024, at 9:25 a.m., the surveyor entered the licensee's facility with unlicensed personnel (ULP)-A and visitor (V)-E. R1 was in their room for an unknown period time without staff members in the facility. ULP-A stayed near the surveyor while V-E sat on the living room couch. On July 8, 2024, at 9:32 a.m., the surveyor began to tour the facility. ULP-A assisted the surveyor in showing them the kitchen and the outdoor refrigerator located in the detached garage. When the surveyor reentered the facility after observing the garage, the surveyor opened a closet door located near the front door and living room, next to a dining room table. The surveyor observed R1, R2, and R3's medication bins and five medical charts belonging to residents and home care clients. The surveyor inquired why the closet door was not locked. ULP-A stated, "I didn't want to waste my time." the door was "stuck", and they were unable to get it to lock. ULP-A stated they were late for transporting two residents to work and were going to fix it when they returned however, the surveyor was at the facility. On July 8, 2024, at approximately 10:21 a.m., during the entrance conference licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated the closet that contained medications and medical records should be locked when staff members were not present.	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36648	A. BUILDING: _____ B. WING _____	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOTAL HOME HEALTH SERVICES LLC	6949 IDAHO AVENUE NORTH BROOKLYN PARK, MN 55428

(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
01880	Continued From page 77 LALD/CNS-C stated ULP were trained to keep the closet door locked. The licensee's Storage / Control of Medications policy dated July 13, 2019, indicated all prescription drugs were securely locked in substantially constructed compartments according to the manufacturer's instructions and only authorized personnel have access to the stored medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to discard expired medication for one of three residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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
01890	Continued From page 78 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 admitted the licensee on February 20, 2024, and began receiving assisted living services. R2's service plan dated February 20, 2024, indicated R2 received assistance with medication management, monthly vital signs, housekeeping, transportation, and meals. On July 8, 2024, at approximately 9:32 a.m., during a facility tour, the surveyor observed a medication closet and observed the following medications expired: - R2 had 1 card of benztropine with an expiration date of May 8, 2023. ULP-A stated they had never seen R2 take the medication listed above and they believed R2 only took the medication when R2 experienced allergy symptoms. R2's medical record lacked an order for the medication listed above. On July 8, 2024, at 11:21 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated expired meds were disposed of through the licensee's pharmacy. LALD/CNS-C stated expired medication should not be located in the medication closet. LALD/CNS-C stated they kept the medication listed above because it was as needed (PRN) for tremors and R2 never requested the medication so they never ordered a new medication from pharmacy when it expired. The licensee's Disposition / Disposal of	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01890	Continued From page 79 Medication policy dated July 13, 2019, indicated discontinued medication may be kept until the expiration dates if there is a possibility of resuming the medication. If not resumed before the expiration date it will be disposed of according to this policy. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
02320 SS=D	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure unlicensed personnel (ULP)-B followed appropriate medication administration procedures for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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02320	Continued From page 80 situation has occurred only occasionally). The findings include: ULP-B was hired on February 20, 2024, to provide direct cares and services to residents. ULP-B's employee record indicated ULP-B received a medication competency evaluation on February 23, 2024. On July 8, 2024, at 10:21 a.m., during the entrance conference, licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated ULP were trained and completed a competency evaluation prior to administering medication. LALD/CNS-C stated ULP were trained to compare the medication card against the medication administration record (MAR). R1's service plan signed February 20, 2024, indicated R1 received assistance with housekeeping, transportation, laundry, meals, medication administration, vital signs monthly, behavior management, and activity of daily living reminders. R1's Medication Administration Record dated July 1, 2024, included metformin 500 milligrams (mg) once daily in the morning, omeprazole 20 mg delayed release (DR) once daily in the morning, Vitamin "3D" (sic) 1000 units (u) once daily in the morning, and olanzapine 20 mg once daily at bedtime. R1's Medication Protocol for Oral Medications signed February 20, 2024, indicated ULP were to check the medication profile for right person, right day, right time, count the number of pills for the day and check for additional instructions. Then	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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02320	Continued From page 81 ULP were to check the medication box for the right person, right day, right time and right number of pills for the day and time prior to medication administration. On July 9, 2024, at 8:39 a.m., the surveyor observed ULP-B remove the medication from the medication closet, remove Vitamin D3 1000 u, metformin extended release (ER) 500 mg, and olanzapine 20 mg from R1's medication card and place in the medication cup. ULP-B asked if R1 wanted their omeprazole in the evening. R1 stated they wanted their omeprazole in the evening. ULP-B then administered the medication listed above to R1. The surveyor did not observe a medication count or verification of orders prior to administration. ULP-B stated they were trained on medication administration by LALD/CNS-C. The surveyor inquired how they knew which medication to administer to R1. ULP-B stated, "it is on the prescription label. I studied their medication administration too." The surveyor inquired how ULP-B knew there was no medication changes. ULP-B stated, " I was sure it did not change cause [sic] every day I do this." The licensee's Medication Administration policy dated July 13, 2019, indicated clients [residents] were entitled to the safe administration of medications by qualified personnel according to a written medication management plan. All staff with responsibility for medication administration have access to information about the medication being administered including but not limited to: - purpose; - dosage; - route; - frequency; - instructions related to the medication and specific to the clients [residents], as appropriate;	02320		

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02320	Continued From page 82 - side effects; and - clients [residents] allergies to medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		

Minnesota Department of Health
Division of Environmental Health, FPLS
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *07/08/24*
Time: 13:00:00
Report: 1025241101

Food and Beverage Establishment Inspection Report

Location:
Total Home Health Services Llc
6949 Idaho Avenue North
Brooklyn Park, MN55428
Hennepin County, 27

Establishment Info:
ID #: 0039247
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 6124420930
ID #:

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

The following orders were issued during this inspection.

5-200B Plumbing: cross connections

5-203.14E ***** Priority 1 *****

MN Rule 4626.1085A Mount the spray arm so it cannot hang below the spill rim of a sink or provide an approved backflow prevention device on the faucet.

Spray arm in sink doesn't fit in the housing, hangs below flood rim. Repair.

Comply By: 07/12/24

4-300 Equipment Numbers and Capacities

4-302.13B ***** Priority 2 *****

MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.

Provide a means of testing the interior temperature of the dishwasher, discussed specific product types during inspection

Comply By: 07/12/24

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.

Employ a CFPM for the license, discussed the MDH CFPM website and process during inspection. Post the CFPM copy when obtained.

Comply By: 07/08/24

Type: Full
Date: *07/08/24*
Time: 13:00:00
Report: 1025241101
Total Home Health Services Llc

Food and Beverage Establishment Inspection Report

4-200 Equipment Design and Construction

4-202.17

MN Rule 4626.0545 Remove kick plates that are not designed to be easily removed for cleaning and inspection.

Provide cabinetry in the kitchen which does not have a hollow enclosed base

Comply By: 10/31/24

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.111ABD

MN Rule 4626.1565ABD Provide control of insects, rodents, and other pests by routinely inspecting incoming food and supply shipments; routinely inspecting the premises for evidence of pests; and eliminating harborage conditions.

Mouse droppings observed under sink and in empty drawer. Provide control of pests and clean interior of cabinets to reduce harborage and make observation easier. Seal holes in cabinets.

Comply By: 07/08/24

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.12A

MN Rule 4626.1520A Clean and maintain all physical facilities clean.

Clean the interior and exterior of the cabinets, pull out appliances and clean behind and underneath, clean stove hood. Clean and sanitize interior of cabinets where mice have been active.

Comply By: 07/12/24

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	1	1	4

Discussed pest control. Thoroughly clean and sanitize the interior of the cabinets and the floor in the kitchen (pull out appliances and clean under and behind), as there were some mouse droppings observed in an empty drawer by the sink and underneath the sink. Seal holes and openings in cabinetry.

Continue storing opened food items in storage containers, and provide food storage containers that are easy enough to clean/sanitize (something small enough and dishwasher safe would probably be the easiest).

Freezer/Refrigerator in garage, discussed not storing TCS foods inside (soda, bread, etc are OK), and checking to make sure items in the freezer stay frozen, esp during warm days during the summer.

Facility has a food thermometer

FACILITY
Appliances are residential, linoleum counter, painted walls, painted wood cabinets

SINK USAGE
Facility has a two (2) compartment sink
Facility has a dishwasher with a sanitize cycle
Facility does not have a 3 compartment sink
Facility does not have a dedicated food preparation sink

COUNTERTOPS AND FOOD CONTACT SURFACES
Provide a smooth, non-porous food contact surface (e.g. cutting boards) that can be easily washed, rinsed, and sanitized (e.g. run through the dishwasher). Soap and water can be used to clean non-food contact surfaces. By provided a cutting board or other non-porous food contact surface, the countertops can be kept clean without the use of substances which may damage the finish. Do not use wood as a food contact surface.

DISHWASHING – NSF 184
Dishwasher has a sanitizing rinse option (NSF/ANSI Standard 184) – use this option to sanitize utensils
Provide a means of testing the internal contact temperature of utensil in the dishwasher
If the sanitize cycle on the dishwasher will not be used, provide an alternate means of chemical sanitizing (e.g. a bus tub or other basin, to be filled with water and sanitizing solution e.g. chlorine bleach (non-scented, labeled for Sanitizing Food Contact Surfaces) at 50-100 PPM; provide a test kit for chemical sanitizing)
Recommend having an alternative means of sanitizing available case of emergency or service interruption

EQUIPMENT
MN 4626.0506 includes alternate equipment and finish requirements for adult care facilities which serve TCS foods for same-day service only:

MN 4626.0506 G. A food establishment that is an adult care center, child care center, or boarding establishment does not need to comply with item A [certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program for food service equipment] if approved by the regulatory authority and the food establishment:
(1) serves only non-TCS food; or
(2) prepares TCS foods only for same-day service.

Discontinue any service of TCS food for multiple day service (e.g. cooling and reservice of leftovers of prepared and cooked TCS food), or upgrade finishes and equipment in the kitchen

GENERAL COMMENTS
CFPM (Certified Food Protection Manager)
For information, please search "MDH CFPM"

Discussed employee health and hygiene, exclusion for individuals from the kitchen with vomiting and/or diarrheal illness, sore throat with fever, or reportable illness; food cooking and holding temperatures, cross-contamination, allergens, food storage order in refrigerator, separating resident food from medication or staff food, avoiding bare hand contact with foods which will not be cooked (cut fruit, deli sandwiches), chemical label, use, and storage, pest control, quarantine meals

Date marking TCS foods (when packages are opened or food is prepared, date mark and discard after 7 days, except for certain cultured dairy products)
Discussed food source, recalls, and refusing food which has signs of tampering or temperature abuse
Information on food recalls available "MDA Food Recall"
https://www.mda.state.mn.us/food-feed/food-recalls-consumer-advisories-minnesota

FACT SHEETS
Please search "MDH Fact Sheets" for the Food Business fact sheets page
"Cleaning and Sanitizing" https://www.health.state.mn.us/communities/environment/food/docs/fs/cleansanfs.pdf
"Food Cooking Temperatures"
https://www.health.state.mn.us/communities/environment/food/docs/fs/timetempfs.pdf
"Date Marking TCS foods"
https://www.health.state.mn.us/communities/environment/food/docs/fs/datemarkingfs.pdf
"Highly Susceptible Populations" - no service or raw or undercooked animal food, use Pasteurized eggs when preparing eggs raw or undercooked or batching scrambled eggs
https://www.health.state.mn.us/communities/environment/food/docs/fs/highsuspopfs.pdf

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 1025241101 of 07/08/24.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/__/____

Inspection report reviewed with person in charge and emailed.

Signed:_____
Establishment Representative

Signed:_____
Casey Kipping
Public Health Sanitarian III
Freeman Building St Paul
651-201-4513
casey.kipping@state.mn.us

Report #: 1025241101

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
Division of Environmental Health, FPLS
P.O. Box 64975
St. Paul, MN 55164-0975

No. of RF/PHI Categories Out	1
No. of Repeat RF/PHI Categories Out	0
Legal Authority MN Rules Chapter 4626	

Date 07/08/24
Time In 13:00:00
Time Out

Total Home Health Services Llc	Address: 6949 Idaho Avenue North	City/State: Brooklyn Park, MN	Zip Code: 55428	Telephone: 6124420930
License/Permit #: 0039247	Permit Holder	Purpose of Inspection: Full	Est Type	Risk Category

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item. Mark "X" in appropriate box for COS and/or R.

IN= in compliance **OUT=** not in compliance **N/O=** not observed **N/A=** not applicable **COS=** corrected on-site during inspection **R=** repeat violation

Compliance Status						COS	R
Surpervision							
1	(IN)	OUT			PIC knowledgeable; duties & oversight		
2	IN	(OUT)	N/A		Certified food protection manager, duties		
Employee Health							
3	(IN)	OUT			Mgmt/Staff;knowledge,responsibilities&reporting		
4	(IN)	OUT			Proper use of reporting, restriction & exclusion		
5	(IN)	OUT			Procedures for responding to vomiting & diarrheal events		
Good Hygenic Practices							
6	(IN)	OUT		N/O	Proper eating, tasting, drinking, or tobacco use		
7	(IN)	OUT		N/O	No discharge from eyes, nose, & mouth		
Preventing Contamination by Hands							
8	(IN)	OUT		N/O	Hands clean & properly washed		
9	(IN)	OUT	N/A	N/O	No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed		
10	(IN)	OUT			Adequate handwashing sinks supplied/accessible		
Approved Source							
11	(IN)	OUT			Food obtained from approved source		
12	IN	OUT	N/A	(N/O)	Food received at proper temperature		
13	(IN)	OUT			Food in good condition, safe, & unadulterated		
14	IN	OUT	(N/A)	N/O	Required records available; shellstock tags, parasite destruction		
Protection from Contamination							
15	(IN)	OUT	N/A	N/O	Food separated and protected		
16	(IN)	OUT	N/A		Food contact surfaces: cleaned & sanitized		
17	(IN)	OUT			Proper disposition of returned, previously served, reconditioned, & unsafe food		

Compliance Status						COS	R
Time/Temperature Control for Safety							
18	IN	OUT	N/A	(N/O)	Proper cooking time & temperature		
19	IN	OUT	N/A	(N/O)	Proper reheating procedures for hot holding		
20	IN	OUT	N/A	(N/O)	Proper cooling time & temperature		
21	IN	OUT	N/A	(N/O)	Proper hot holding temperatures		
22	(IN)	OUT	N/A		Proper cold holding temperatures		
23	(IN)	OUT	N/A	N/O	Proper date marking & disposition		
24	IN	OUT	(N/A)	N/O	Time as a public health control: procedures & records		
Consumer Advisory							
25	IN	OUT	(N/A)		Consumer advisory provided for raw/undercooked food		
Highly Susceptible Populations							
26	(IN)	OUT	N/A		Pasteurized foods used; prohibited foods not offered		
Food and Color Additives and Toxic Substances							
27	IN	OUT	(N/A)		Food additives: approved & properly used		
28	(IN)	OUT			Toxic substances properly identified, stored, & used		
Conformance with Approved Procedures							
29	IN	OUT	(N/A)		Compliance with variance/specialized process/HACCP		

Risk factors (RF) are improper practices or proceedures identified as the most prevalent contributing factors of foodborne illness or injury. **Public Health Interventions** (PHI) are control measures to prevent foodborne illness or injury.

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" in box if numbered item is **not** in compliance. Mark "X" in appropriate box for COS and/or R. **COS=** corrected on-site during inspection **R=** repeat violation

			COS	R
Safe Food and Water				
30	IN OUT (N/A)	Pasteurized eggs used where required		
31		Water & ice obtained from an approved source		
32	IN OUT (N/A)	Variance obtained for specialized processing methods		
Food Temperature Control				
33		Proper cooling methods used; adequate equipment for temperature control		
34	IN OUT N/A (N/O)	Plant food properly cooked for hot holding		
35	IN OUT N/A (N/O)	Approved thawing methods used		
36		Thermometers provided & accurate		
Food Identification				
37		Food properly labled; original container		
Prevention of Food Contamination				
38	X	Insects, rodents, & animals not present		
39		Contamination prevented during food prep, storage & display		
40		Personal cleanliness		
41		Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		

			COS	R
Proper Use of Utensils				
43		In-use utensils: properly stored		
44		Utensils, equipment & linens: properly stored, dried, & handled		
45		Single-use/single service articles: properly stored & used		
46		Gloves used properly		
Utensil Equipment and Vending				
47	X	Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48	X	Warewashing facilities: installed, maintained, & used; test strips		
49		Non-food contact surfaces clean		
Physical Facilities				
50		Hot & cold water available; adequate pressure		
51	X	Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities: properly constructed, supplied, & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55	X	Physical facilities installed, maintained, & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing & plan review		

Food Recalls:

Person in Charge (Signature) **Date:** 07/08/24

Inspector (Signature) Gary King