DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

August 31, 2022

Administrator
The Hummingbird
7704 Cole Avenue
Meadowlands, MN 55765

RE: Project Number(s) SL30728015

Dear Administrator:

On August 30, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine if orders from the June 16, 2022, evaluation were corrected. This follow-up evaluation verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

Jessie Chenze, RN, BSN
Interim HFE Supervisor 1 | State Evaluations Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Office: 218-332-51751 | Mobile: 651-508-2791| Fax: 218-332-5196

Electronically Delivered

July 6, 2022

Administrator
The Hummingbird
7704 Cole Avenue
Meadowlands, MN 55765

RE: Project Number(s) SL30728015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on June 16, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

In accordance with Minn. Stat. § 144G.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation

that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The Department of Health also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5)(b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

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

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program = $500.00
St - 0 - 2310 - 144g.91 Subd. 4 - Appropriate Care And Services = $3,000.00

The total amount you are assessed is $3,500. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

Please address your cover letter for general Free from Maltreatment reconsideration

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

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

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. Requests for hearing may be emailed to **Health.HRD.Appeals@state.mn.us**.

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,

Jessie Chenze, RN, BSN
Interim HFE Supervisor 1 | State Evaluations Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Office: 218-332-51751 | Mobile: 651-508-2791| Fax: 218-332-5196

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30728	A. BUILDING: _____ B. WING _____	06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HUMMINGBIRD	7704 COLE AVE MEADOWLANDS, MN 55765

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(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: SL#30728015 On, June 13, 2022, through June 16, 2022, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 11 residents, all were receiving services under the provider's Assisted Living with Dementia Care license. An immediate correction order was identified on June 14, 2022, issued for SL30728015, tag identification 2310. On June 14, 2022, the immediacy of correction order 2310 was removed, however non-compliance remained at a scope and level of G.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 110 SS=F	144G.10 Subdivision 1a Assisted living director license required	0 110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30728	A. BUILDING: _____ B. WING _____	06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HUMMINGBIRD	7704 COLE AVE MEADOWLANDS, MN 55765

(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
0 110	Continued From page 1 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 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 two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference June 13, 2022, at approximately 9:45 a.m., LALD/owner (LALD/O)-A stated he was the LALD for the facility. LALD/O-A obtained an assisted living director license on July 14, 2021. On June 13, 2022, at approximately 10:15 a.m., the Board of Executives for Long-Term Services and Support (BELTSS) website, indicated LALD-A held a current assisted living director license. The BELTSS website did not indicate LALD/O-A was	0 110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30728	A. BUILDING: _____ B. WING _____	06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HUMMINGBIRD	7704 COLE AVE MEADOWLANDS, MN 55765

(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
0 110	Continued From page 2 listed as the Director of Record for the licensee. On June 13, 2022, at 10:16 a.m., LALD/O-A confirmed he was not listed as the Director of Record for the licensee. No further information 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 access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's	0 250		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30728	A. BUILDING: _____ B. WING _____	06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HUMMINGBIRD	7704 COLE AVE MEADOWLANDS, MN 55765

(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
0 250	Continued From page 3 residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4; (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 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	0 250		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30728	A. BUILDING: _____ B. WING _____	06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HUMMINGBIRD	7704 COLE AVE MEADOWLANDS, MN 55765

(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
0 250	Continued From page 4 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 June 13, 2022, at 9:39 a.m., licensed assisted living director/owner (LALD-O)-A and licensed practical nurse/owner (LPN/O)-B confirmed they were responsible for and participated in the facility's day-to-day operations. LALD/O-A stated he was familiar with the Assisted Living with Dementia licensing rules. 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 (opens in a new window), 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 (opens in a new window). - I have read and fully understand Minn. Stat. sect. 144G.80 (opens in a new window), 144G.81 (opens in a new window). and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22 (opens in a new window), my building(s) must comply with these sections if applicable.	0 250		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30728	A. BUILDING: _____ B. WING _____	06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HUMMINGBIRD	7704 COLE AVE MEADOWLANDS, MN 55765

(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
0 250	Continued From page 5 - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G (opens in a new window). - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659 (proposed and not final) (opens in a new window). - Reporting of Maltreatment of Vulnerable Adults (opens in a new window). - Electronic Monitoring in Certain Facilities (opens in a new window). - I understand pursuant to Minn. Stat. sect. 13.04 Rights of Subjects of Data (opens in a new window), 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, ins some circumstances, be disclosed to the appropriate state, federal or local agency and law enforcement office to enhance investigative or enforcement efforts or further a public health protective process. Types of offices include Adult Protective Services, offices of the ombudsmen, health-licensing boards, Department of Human Services, county or city attorneys' offices, police, local or county public health offices. - I understand in accordance with Minn. Stat. sect. 144.051 Data Relating to Licensed and	0 250		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30728	A. BUILDING: _____ B. WING _____	06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HUMMINGBIRD	7704 COLE AVE MEADOWLANDS, MN 55765

(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
0 250	Continued From page 6 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 (opens in a new window), and Minnesota Rules, chapter 4659 (proposed and not final) (opens in a new window), 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 (opens in new window). and Minn. Rules chapter 4659 (proposed and not final) (opens in new window), in place upon licensure and to keep them current as applicable. Page five was electronically signed by the owner agent, LALD/O-A on June 8, 2021. The licensee had an assisted living with dementia license issued on August 1, 2021, with an	0 250		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30728	A. BUILDING: _____ B. WING _____	06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HUMMINGBIRD	7704 COLE AVE MEADOWLANDS, MN 55765

(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
0 250	Continued From page 7 expiration date of July 31, 2022. The licensee had attested they read and understood the Assisted Living/Dementia Care licensing statues. The licensee failed to implement the following required policies and procedures: - orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; - infection control practices; - medication and treatment management; -supervision of unlicensed personnel (ULP) performing delegated tasks. On June 15, 2022, at approximately 10:54 a.m., LALD/O-A and LPN/O-B confirmed the above listed policies and procedures had not been successfully implemented. As a result of this survey, the following orders were issued 0110, 0250, 0480, 0485, 0510, 0580, 0680, 0780, 0790, 0800, 0810, 0970, 1420, 1440, 1640, 1760, 1790, 1890, 2040, 2110, 2140, 2310 and 2350 indicating the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.08 to 144G.95. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 250		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30728	A. BUILDING: _____ B. WING _____	06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HUMMINGBIRD	7704 COLE AVE MEADOWLANDS, MN 55765

(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
0 480	Continued From page 8	0 480		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated June 13, 2022, for the specific Minnesota Food Code deficiencies.	0 480		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30728	A. BUILDING: _____ B. WING _____	06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HUMMINGBIRD	7704 COLE AVE MEADOWLANDS, MN 55765

(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
0 480	Continued From page 9 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 485 SS=C	144G.41 Subd 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; (C) the facility cannot require a resident to include and pay for meals in their contract; This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to post a menu a week in advance that was made available to all residents. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a	0 485		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30728	A. BUILDING: _____ B. WING _____	06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HUMMINGBIRD	7704 COLE AVE MEADOWLANDS, MN 55765

(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
0 485	Continued From page 10 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: During the entrance conference June 13, 2022, at approximately 9:43 a.m., licensed assisted living director/owner (LALD/O)-A stated the licensee provided three meals daily to include fresh fruit and vegetables and snacks were offered. During a tour of the licensed facility on June 13, 2022, at 10:18 a.m., the surveyor observed a single-day menu dated June 13, 2022, posted to the wall in the kitchen under a cabinet. On June 13, 2022, at 1:18 p.m., licensed practical nurse/owner (LPN/O)-B explained how cycle menus were used. LPN/O-B verified a menu was not posted for the week, "it is supposed to be right here. I wonder why it is not". This was said as LPN/O-B was pointing to an informational board posted in a hallway next to the kitchen area. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities.	0 510		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30728	A. BUILDING: _____ B. WING _____	06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HUMMINGBIRD	7704 COLE AVE MEADOWLANDS, MN 55765

(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
0 510	Continued From page 11 (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure infection control standards were followed for one out of one unlicensed personnel (ULP-F) during personal cares for R2. In addition, licensee failed to establish and maintain an effective infection control program that complied with accepted health care, medical and nursing standards for infection control related to COVID-19, consistent with current guidelines from the Centers for Disease Control and Prevention (CDC) related to wearing appropriate PPE (personal protective equipment). 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: HAND HYGIENE On June 14, 2022, at approximately 7:00 a.m., surveyor observed ULP-F in R2's room wearing gloves. R2 was lying in bed with support hose (TEDs) on his lower extremities. ULP-F left R2's room, went to a cart which was positioned outside of the kitchen area to get a book with R2's name on it. ULP-F took the book to R2's room and flipped through it and signed off on the application	0 510		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30728	A. BUILDING: _____ B. WING _____	06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HUMMINGBIRD	7704 COLE AVE MEADOWLANDS, MN 55765

(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
0 510	Continued From page 12	0 510		

of TEDs. ULP-F went to the bathroom in R2's room to get an alcohol pad. ULP-F opened the alcohol pad foil package and unfastened the tube from catheter (a tube inserted into the bladder, allowing urine to drain freely) bed bag (larger urine collection bag) hose and then cleaned the tip of the leg bag (smaller urine collection bag) tube and connected it to the leg bag. ULP-F took the catheter bed bag to the bathroom, drained it, and ran water from the sink into it while it drained into the toilet. ULP-F flushed the toilet, removed gloves, and applied new gloves. ULP-F went to a door labeled "staff only" and got a spray bottle of pink solution (73 disinfecting acid bathroom cleaner) and paper towels. ULP-F wiped down the countertop and the toilet tank cover with the pink solution. ULP-F returned the pink solution to the room he got it from and returned to R2's room. ULP-F used the remote to put the TV on and then proceeded to secure the leg bag straps around R2's calf and partly pull up R2's brief and pants. R2 was assisted out of bed with the aid of a sit to stand lift (a mechanical device to aide in transfer of persons with limited weight bearing ability) his lower body dressing was completed and was seated in a wheelchair. ULP-F removed gloves, picked up the book with R2's name on it and signed off that catheter care had been completed. ULP-F took R2 to the sink and applied gloves. ULP-F removed R'2 dentures from a denture cup, rinsed and brushed them before applying an adhesive to R2's lower denture. ULP-F removed gloves and applied new gloves. ULP-F opened the medication cabinet and removed a topical medication which he applied to R2's upper right shoulder and right hand (dicofenax sodium 1%.) ULP-F removed gloves and applied new gloves. ULP-F dressed R2's upper body and combed R2's hair. ULP-F went to the medication cabinet and removed two

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30728	A. BUILDING: _____ B. WING _____	06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HUMMINGBIRD	7704 COLE AVE MEADOWLANDS, MN 55765

(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
0 510	Continued From page 13	0 510		

alcohol pads, blood glucose meter, one sample strip and lancet device (used to make a small prick in the skin for blood sample). ULP-F cleaned R2's left thumb with an alcohol pad and used the lancet. to obtain a sample and completed the blood glucose test. ULP-F handed R2 an alcohol pad to use where the sample had been taken from. ULP-F returned the supplies to the medication cabinet. ULP-F removed an insulin pen from the medication cabinet then removed the gloves he had worn and applied new gloves. ULP-F stated, "I am kind of a freak about changing gloves." ULP-F administered the insulin into R2's abdomen and returned insulin pen to the cabinet. ULP-F went to the kitchen to get a small amount of yogurt and returned to R2's room. ULP-F unlocked the medication cabinet and took out a medication pill box. He put the medication into a medication cup and then put the medications into the yogurt and administrated the medication to R2. ULP-F removed gloves. ULP-F did not complete hand hygiene at any point during the surveyor's observations.

On June 14, 2022, at 7:24 a.m., directly following the above noted observation, ULP-F confirmed hand hygiene was not completed as required. ULP-F added gloves should be worn "if you touch a doorknob or something. I think hands are contaminated."

On June 14, 2022, at 10:10, registered nurse (RN)-C stated hands should be washed "if visibly unclean or dirty, and during medication administration." RN-C verified hands should be washed as well as gloves worn.

The licensee's Hand Washing policy reviewed September 1, 2018, verified hand washing would be performed between client cares and whenever

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30728	A. BUILDING: _____ B. WING _____	06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HUMMINGBIRD	7704 COLE AVE MEADOWLANDS, MN 55765

(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
0 510	Continued From page 14 direct physical contact with a client takes place. Use of gloves does not replace hand washing. Hands should be washed or decontaminated: a. Before and after direct contact with a client; b. If moving from a contaminated-body site to a clean-body site during client care; c. After contact with environmental surfaces or equipment in the immediate vicinity of the client; d. After removing gloves or gowns; and e. Before eating and after using a restroom. PERSONAL PROTECTIVE EQUIPMENT (PPE) The Minnesota Department of Health (MDH) guidance titled, "COVID-19 [personal protective equipment (PPE)] and Source Control Grids - for congregate care settings, by community transmission level", dated April 7, 2022, indicated during "substantial" or "high" levels of community transmission (based on the Centers for Disease Control and Prevention (CDC) online data tracking system), caregivers must wear a face mask (source control) and eye protection while working with clients without suspected or confirmed SARS-CoV-2 infection. On June 14, 2022, at approximately 7:00 a.m., the surveyor observed ULP-F providing personal cares to R2 not wearing eye protection. On June 14, 2022, at approximately 7:10 a.m., the surveyor observed ULP-E assist ULP-F use a sit to stand lift for R2 not wearing eye protection. On June 14, 2022, at 10:54 a.m., RN-C confirmed eye protection was not being worn. "I don't know that they have ever worn eye protection. I know they have all been wearing masks and checking symptoms". RN verified staff were not wearing eye protection at this time.	0 510		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30728	A. BUILDING: _____ B. WING _____	06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HUMMINGBIRD	7704 COLE AVE MEADOWLANDS, MN 55765

(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
0 510	Continued From page 15 On June 15, 2022, at approximately 9:00 a.m., the surveyor and licensed assisted living director (LALD)-A confirmed the Centers for Disease Control and Prevention (CDC) Covid-19 Data Tracker website indicated covid transmission levels were high within the county the facility is located. The LALD-A took a photo of the web address so he would have it. The licensee's COVID-19 policy reviewed March 26, 2022, indicates Standard Precautions should be used for all residents, all the time; -hand hygiene; -use of personal protective equipment (e.g., gloves, gowns, masks); -safe handling of potentially contaminated equipment or surfaces in the resident's environment; and -respiratory hygiene/cough etiquette. No further information provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 510		
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for	0 580		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30728	A. BUILDING: _____ B. WING _____	06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HUMMINGBIRD	7704 COLE AVE MEADOWLANDS, MN 55765

(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
0 580	Continued From page 16 two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to implement and maintain a quality management program appropriate to the size of the facility and relevant to the type of services provided. This had the potential to affect all current clients, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On June 13, 2022, at 10:02 a.m., during the entrance conference with the licensed assisted living director/owner (LALD/O)-A, a request was made to review documentation of the licensee's quality management activities. LALD/O-A stated he was unaware of the requirement adding he did not have a quality management program. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 580		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness	0 680		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30728	A. BUILDING: _____ B. WING _____	06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HUMMINGBIRD	7704 COLE AVE MEADOWLANDS, MN 55765

(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
0 680	Continued From page 17 (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to have a written emergency preparedness plan with all the required content and failed to post an emergency preparedness plan (EPP) prominently. This had the potential to affect all 11 residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 680		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30728	A. BUILDING: _____ B. WING _____	06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HUMMINGBIRD	7704 COLE AVE MEADOWLANDS, MN 55765

(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
0 680	Continued From page 18 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On June 13, 2022, at approximately 10:15 a.m., the surveyor toured the facility with licensed assisted living director /owner (LALD/O)-A. There was no observed signage posted or information regarding the licensee's EPP in the common areas of the facility. On June 13, 2022, at 11:00 a.m., licensed practical nurse/owner (LPN/O)-B verified there were no exit diagrams posted, "waiting to get a nice designed copy from architect." On June 13, 2022, at approximately 1:30 p.m., the surveyor requested the licensee's emergency preparedness plan. Two binders, one included general instructions for some emergencies, such as what to do in the case of a tornado, severe weather, bomb threat, etc. and a separate binder regarding fire information were given to surveyor. The licensee's emergency preparedness plan lacked a Hazard Vulnerability Assessment and the following required content: - a description of the population served by the licensee; - process for emergency preparedness (EP) cooperation with state and local EP officials/organizations; - subsistence needs for staff and residents during	0 680		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30728	A. BUILDING: _____ B. WING _____	06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HUMMINGBIRD	7704 COLE AVE MEADOWLANDS, MN 55765

(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
0 680	Continued From page 19 emergency situation; - development of policies/procedures to address: - an evacuation plan customized for the facility; - shelter in place; - emergency staff strategies; and - the licensee's role in providing care and treatment at alternative sites. - a communication plan that addressed: - arrangements with other facilities; - names and contact information for staff, resident physicians, and other facilities; - contact information for federal, state, tribal, local EP staff, and ombudsman; - primary and alternative means for communicating with facility staff, federal, state, regional and local emergency management agencies; - a method of sharing resident information and medical documentation; - a means to provide information regarding the facility's needs, and its ability to provide assistance, including occupancy information; and -a method of sharing information from the licensee's emergency plan with residents and their families. - EP training and testing program; - EP training program for staff (including documentation of training provided); and - EP testing/annual testing requirements. On June 13, 2022, at approximately 1:40 p.m., LALD/O-A verified the facility had a generator. He stated tracking of staff and residents would be done via the on-line system and all medical information was in the on-line system also, adding the plan would be to bring residents to a warehouse or fire station if an evacuation was needed.	0 680		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30728	A. BUILDING: _____ B. WING _____	06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HUMMINGBIRD	7704 COLE AVE MEADOWLANDS, MN 55765

(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
0 680	Continued From page 20 On June 13, 2022, at 1:47 p.m., LALD/O-A left the room while the interview was still in progress. The licensee's Plans For Natural Disasters and Emergencies policy reviewed September 1, 2018, confirmed establishments would have a written emergency disaster plan that would include: - a plan for evacuation; - addresses elements of sheltering in-place; -identifies temporary relocation sites - details staff assignment in the event of a disaster or emergency; -post an emergency disaster plan prominently; -provide building emergency exit diagrams to all tents upon signing a lease; -post emergency exit diagrams on each floor; and -have a written policy and procedure regarding missing tenants. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
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;	0 780		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30728	A. BUILDING: _____ B. WING _____	06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HUMMINGBIRD	7704 COLE AVE MEADOWLANDS, MN 55765

(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
0 780	Continued From page 21 (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that complied with fire protection requirements. This had the potential to directly affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On June 16, 2022, between 10:45 a.m. and 11:30 a.m., survey staff toured the facility with the licensed assisted living director (LALD)-A. During the facility tour, survey staff observed the following: 1. The smoke alarm was missing from the bracket on the ceiling in resident sleeping room 8. 2. A smoke alarm was not installed in resident sleeping room 11. This room had previously been	0 780		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30728	A. BUILDING: _____ B. WING _____	06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HUMMINGBIRD	7704 COLE AVE MEADOWLANDS, MN 55765

(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
0 780	Continued From page 22 used as a den and was provided with a smoke detector. During an interview, at approximately 12:05 p.m., the LALD-A confirmed that smoke alarms needed to be installed in these residents sleeping rooms. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the portable fire extinguishers. This had the potential to directly affect all residents and staff. 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	0 790		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30728	A. BUILDING: _____ B. WING _____	06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HUMMINGBIRD	7704 COLE AVE MEADOWLANDS, MN 55765

(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
0 790	Continued From page 23 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On June 16, 2022, between 10:45 a.m. and 11:30 a.m., survey staff toured the facility with the licensed assisted living director (LALD)-A. During the facility tour, survey staff observed portable fire extinguishers with service tags that were punched with a date of September 2020. During the tour interview, the LALD-A confirmed that the portable fire extinguishers tags were dated 2020 and that maintenance needed to be completed annually by a service company. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) 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 provide the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly	0 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30728	A. BUILDING: _____ B. WING _____	06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HUMMINGBIRD	7704 COLE AVE MEADOWLANDS, MN 55765

(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
0 800	Continued From page 24 affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On June 16, 2022, between 10:45 a.m. and 11:30 a.m., survey staff toured the facility with the licensed assisted living director (LALD)-A. During the facility tour, survey staff observed the following: 1. Two doors were not provided with locking mechanisms that opened into a corridor from resident room 11. 2. There was an opening in the wall between resident room 11 and the main kitchen. The opening had been covered with a window blind. When the blind was opened, there was direct access into the kitchen through this space. During the facility tour, the LALD-A explained that room 11 had been converted into a resident room. The LALD-A confirmed during the tour interview that the doors required locks and that the wall opening needed to be enclosed. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30728	A. BUILDING: _____ B. WING _____	06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HUMMINGBIRD	7704 COLE AVE MEADOWLANDS, MN 55765

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 810	Continued From page 25 (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, document review, and interview, the licensee failed to provide the required plans, training, and drills for fire safety and evacuation. This had the potential to directly	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30728	A. BUILDING: _____ B. WING _____	06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HUMMINGBIRD	7704 COLE AVE MEADOWLANDS, MN 55765

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 810	Continued From page 26 affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On June 16, 2022, between 10:45 a.m. and 11:30 a.m., survey staff toured the facility with the licensed assisted living director (LALD)-A. During the facility tour, survey staff observed that the location and number of resident sleeping rooms were not identified on the evacuation map posted near the kitchen. On June 16, 2022, at 11:30 a.m., the LALD-A provided documents for review. Documents were reviewed by survey staff on June 16, 2022, between 11:30 a.m. and 12:00 p.m. 1. The plans failed to include the identification of unique or unusual resident needs for movement or evacuation. 2. Employee training frequency for the fire safety and evacuation plans was completed upon hire and annually. Employees were not receiving training at least twice per year after hire. 3. Annual resident training on fire safety and evacuation was not being documented. 4. Evacuation drills have not been conducted. On June 16, 2022, at approximately 12:05 p.m., the LALD-A confirmed during an interview that the evacuation maps and plans required revision. They also confirmed that the training and drill frequency requirements were not met.	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30728	A. BUILDING: _____ B. WING _____	06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HUMMINGBIRD	7704 COLE AVE MEADOWLANDS, MN 55765

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 810	Continued From page 27 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 970 SS=C	144.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living with dementia care contract did not include language waiving the facility's liability for health, safety, or personal property of a resident (R1, R2, R3). This had the potential to affect all residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On June 13, 2022, at approximately 10:05 a.m.,	0 970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30728	A. BUILDING: _____ B. WING _____	06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HUMMINGBIRD	7704 COLE AVE MEADOWLANDS, MN 55765

(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
0 970	Continued From page 28 during the entrance conference, a copy of the facility's admission package was requested to include the assisted living contract. The assisted living contract included a clause that indicated the resident would waive the facility's liability for personal property of the resident. Page 13, section 27, of the contract stated, the [facility] will not be responsible for lost or damaged eyeglasses, hearing aids or dentures/partials. "We will do everything we can to ensure all eyeglasses, hearing aids and dentures/partials are safe and in good repair." On June 2022, at 11:43 a.m., licensed practical nurse/owner (LPN/O)-B confirmed the same assisted living contract was used for all residents at the facility. LPN/O-B stated she was not aware the facility could not include that statement in the contract. No futher information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 970		
01420 SS=F	144G.62 Subd. 2 Delegation of assisted living services (b) When the registered nurse or licensed health professional delegates tasks to unlicensed personnel, that person must ensure that prior to the delegation the unlicensed personnel is trained in the proper methods to perform the tasks or procedures for each resident and is able to demonstrate the ability to competently follow the procedures and perform the tasks. If an unlicensed personnel has not regularly performed the delegated assisted living task for a period of	01420		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30728	A. BUILDING: _____ B. WING _____	06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HUMMINGBIRD	7704 COLE AVE MEADOWLANDS, MN 55765

(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
01420	Continued From page 29	01420		

24 consecutive months, the unlicensed personnel must demonstrate competency in the task to the registered nurse or appropriate licensed health professional. The registered nurse or licensed health professional must document instructions for the delegated tasks in the resident's record.

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)-C provided training for unlicensed personnel (ULP)-E and all other staff on the delegated task of body alarm use. In addition, the licensee failed to ensure the RN documented instructions for the delegated tasks in the resident's record (R2, R3).

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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:

TRAINING
ULP-E was hired July 5, 2020, under the comprehensive home care license and began providing assisted living services on August 1, 2021.

On June 13, 2022, at approximately 11:30 a.m., the surveyor observed ULP-E assist R3 out of a reclining chair in the common's area. R3 had a tab alarm (personal alarm with a pull string that is to be attached to a person, when the string is

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30728	A. BUILDING: _____ B. WING _____	06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HUMMINGBIRD	7704 COLE AVE MEADOWLANDS, MN 55765

(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
01420	Continued From page 30	01420		

pulled from the unit an alarm sounds) attached to her. The unsecured tab alarm was placed on the top of the reclining chair.

ULP-E's record lacked documentation to indicate ULP-E had received training and demonstrated competency for a tab alarm.

On June 16, 2022, at 7:57 a.m., RN-C confirmed ULP-E nor any of the other ULPs had been trained and demonstrated competency for providing assistance with tab alarm.

INSTRUCTIONS
R2
R2's diagnoses included cerebrovascular accident (CVA-stroke), chronic obstructive pulmonary disease (COPD) [a group of diseases that cause airflow blockage and breathing-related problems], high blood pressure, and osteoarthritis.
R2's Clinical Update Summary dated April 24, 2022, indicated R2 required assistance with catheter care (a tube inserted into the bladder, allowing urine to drain freely) noting resident has a large urinary output, leg bag to be emptied twice on morning (AM) shift and afternoon (PM) shift and once on the night shift due to having the bigger bed bag on at night. Foley catheter care twice a day.
R2's Service Chart Monthly report dated June 1, 2022, through June 14, 2022, indicated staff were to empty urine bag and document on flow sheet (2:00 am, 6:00 am., 12:00 p.m., 3:00 p.m., 6:00 p.m., 10:00 p.m.), and assist in changing bag using ascetic technique (8:00 a.m., 8:00 p.m.). Wear gloves, clean Foley tip and bag extension tip with alcohol. Report to licensed practical nurse (LPN) any change in urine color, decreased output, blood in urine, odor, increase in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30728	A. BUILDING: _____ B. WING _____	06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HUMMINGBIRD	7704 COLE AVE MEADOWLANDS, MN 55765

(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
01420	Continued From page 31 temperature. R2's Foley Catheter Information sheet dated June 1, 2022, through June 14, 2022, instructed staff to document the following; as scheduled- Please be careful when emptying Foley bag into measuring hat. Place a towel under the hat so urine doesn't drip on the carpet (or empty in bathroom). Please be careful not to pull on the Foley catheter tubing. Place drain bag below bladder. On June 14, 2022, at approximately 7:10 a.m., the surveyor observed ULP-F assisting R2 with personal cares to included catheter care. ULP-F disconnected a hose from catheter bed bag (larger urine collection bag) and attached hose to a leg bag (smaller urine collection bag). ULP-F took the catheter bed bag to the bathroom, drained it [catheter bag] and ran water from the sink into the hose while draining it into the toilet. ULP-F used a pink solution (73 disinfecting acid bathroom cleaner) and paper towels to wipe down the countertop and the toilet tank cover. On June 15, 2022, at 11:07 a.m., RN-C stated catheter cleaning was to occur every night with soapy water. R2's record lacked to include these instructions. R3 R3's diagnoses included memory deficit, osteoarthritis, insomnia, depression anxiety, and fatigue. R3's Clinical Update Summary dated March 26, 2022, indicated R3 utilized both a body and a bed alarm. R3's Service Chart Monthly report dated June 1, 2022, through June 13, 2022, indicated: -AM -body alarm on at all times. Respond immediately; -PM- body alarm on at all times. Bed alarm on when resident is in bed. Respond immediately; -Overnight-body alarm on at all times. Bed alarm on when in bed. Respond immediately.	01420		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30728	A. BUILDING: _____ B. WING _____	06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HUMMINGBIRD	7704 COLE AVE MEADOWLANDS, MN 55765

(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
01420	Continued From page 32 On June 15, 2022, at 8:50 a.m., the surveyor observed R3 in the common's area siting in a recliner in a reclined position. A wheelchair was positioned next to her, and a body alarm secured to the wheelchair. The string was not attached to R3. On June 15, 2022, at 9:01 a.m., the surveyor and LPN-D observed R3 resting. LPN-D confirmed the alarm was not attached to R3. LPN-D attached the alarm to R3. On June 16, 2022, at 7:57 a.m., RN-C verified R3 was to wear an alarm to prevent falls and let staff know R3 needed transfer assist. RN-C added she was considering reassessing; it had been at least two years since R3 had fallen. RN-C confirmed instructions for the alarm were not complete. The licensee's Delegation of Nursing Tasks, Treatments or Therapy Tasks policy dated September 1, 2018, verified RN would delegate nursing services to ULP's only after determining that the unlicensed person is trained and competent and has been instructed in the proper methods to perform the procedures with respect to the specific client. In addition, the RN or authorized Licensed Health Professional would develop written specific instructions for each client and document those instructions in the client's record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) day	01420		
01440 SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living	01440		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30728	A. BUILDING: _____ B. WING _____	06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HUMMINGBIRD	7704 COLE AVE MEADOWLANDS, MN 55765

(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
01440	Continued From page 33	01440		

facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident.
(b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer.

This MN Requirement is not met as evidenced by:
Based on observation, interview, and record review, the licensee failed to ensure direct supervision of staff performing delegated tasks was provided within 30 calendar days after the date on which the individual began working for the licensee for one of two unlicensed personnel (ULP)-F with records reviewed.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), 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:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30728	A. BUILDING: _____ B. WING _____	06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HUMMINGBIRD	7704 COLE AVE MEADOWLANDS, MN 55765

(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
01440	Continued From page 34 On June 14, 2022, at approximately 7:10 a.m., the surveyor observed ULP-F assisting R2 with personal cares including catheter care (a tube inserted into the bladder allowing urine to drain freely), use a sit to stand lift (a mechanical device to aide in transfer of persons with limited weight bearing ablitliy), blood glucose monitoring, and medication administration to include topical, oral, and injectable medications. ULP-F was hired on April 5, 2021, to provide direct care services to residents at the assisted living with dementia care facility. ULP-F's employee record lacked documentation registered nurse (RN)-C supervised ULP-F performing a delegated task within 30 days of beginning work with the licensee. On June 14, 2022, at 10:12 a.m., RN-C stated, "I watch them [ULP] with transfers, bed baths, getting ready for the day, medications, whatever they are doing that day" confirming not all staff had been supervised by RN performing a delegated task." On June 15, at 10:30 a.m., licensed pratical nurse/owner (LPN/O)-B verified ULP-F's 30-day supervision of delegated tasks had not been completed, "it got missed." The licensee's Supervision of Licensed and Unlicensed Personnel reviewed September 1, 2018, confirmed direct supervision of unlicensed staff providing delegated nursing tasks, delegated treatments or assigned therapy tasks would be performed within 30 days after the person begins work for their agency and had been trained and determined competent to perform all the tasks assigned. In addition, documentation of	01440		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30728	A. BUILDING: _____ B. WING _____	06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HUMMINGBIRD	7704 COLE AVE MEADOWLANDS, MN 55765

(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
01440	Continued From page 35 supervision would be in staff person's personnel file. No further information as provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01440		
01640 SS=F	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure three of	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30728	A. BUILDING: _____ B. WING _____	06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HUMMINGBIRD	7704 COLE AVE MEADOWLANDS, MN 55765

(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
01640	Continued From page 36 three residents' (R1, R2, R3) service plans were revised with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 R1's diagnoses included, schizophrenia, depression, anxiety, diabetes, and chronic pain. R1's service plan dated December 1, 2021, indicated R1 received services which included assistance with ambulation/exercise, bathing, dressing, escorts, grooming, housekeeping, laundry, meal trays, toileting, medication, skin care, safety checks, and vital sign monitoring to include pain. R1's service plan did not indicate the resident was receiving any blood glucose monitoring. R1's prescriber orders dated June 3, 2022, included Accu-checks (blood sugar monitoring) one day a week. R2 R2's diagnoses included, cerebrovascular accident (CVA-stroke), chronic obstructive pulmonary disease (COPD) [a group of diseases that cause airflow blockage and breathing-related problems], high blood pressure, and osteoarthritis.	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30728	A. BUILDING: _____ B. WING _____	06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HUMMINGBIRD	7704 COLE AVE MEADOWLANDS, MN 55765

(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
01640	Continued From page 37 R2's service plan dated August 1, 2021, indicated R2 received services which included assistance with ambulation/exercise, bathing, dressing, escorts, grooming, housekeeping, laundry, meal trays, toileting, medication, skin care, transfers, toileting/incontinence care, safety checks, vital sign monitoring and blood glucose recording two times a day. R2's MD Visit form/MD orders dated April 28, 2022, included Accu-checks three times a day; 8:00am, 12:00 pm, 5:00 pm. R3 R3's diagnoses included memory deficit, osteoarthritis, insomnia, depression anxiety, and fatigue. R3's service plan dated October 1, 2021, indicated R3 received services which included assistance with ambulation/exercise, bathing, dressing, escorts, grooming, housekeeping, laundry, meal trays, toileting, medication, skin care, toileting/incontinence care, safety checks, and vital sign monitoring. R3's service plan did not indicate the resident was receiving any assistance with a personal alarm system. On June 13, 2022, at approximately 11:30 a.m., the surveyor observed ULP-E assist R3 out of a reclining chair in the common's area with a body alarm (personal alarm with a pull string that is to be attached to a person, when the string is pulled from the unit an alarm sounds) attached to her. On June 14, 2022, at 1:37 p.m., licensed practical nurse/owner (LPN/O)-B confirmed R1's and R2's	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30728	A. BUILDING: _____ B. WING _____	06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HUMMINGBIRD	7704 COLE AVE MEADOWLANDS, MN 55765

(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
01640	Continued From page 38 service plans were not revised when blood glucose monitoring changed. On June 14, 2022, at 3:34 p.m., LPN-D confirmed R3's service plan was not revised to include use of a personal alarm system. On June 15, 2022, at 7:57 a.m., registered nurse (RN)-C verified R1, R2, R3's service plans were not revised, adding "Oh, ok, I don't create them, the service plans, it should be there, it is on over site. The licensee's Development and Revision of the Service Plan policy dated September 1, 2018, indicated if client's service plan needs modification based on client's needs, preferences, or changes in fee, the RN, therapist and/or other licensed health professional (as applicable) makes necessary changes to the service plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30728	A. BUILDING: _____ B. WING _____	06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HUMMINGBIRD	7704 COLE AVE MEADOWLANDS, MN 55765

(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
01760	Continued From page 39	01760		

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 ensure staff administered medications according to manufacturer's instructions with insulin administration via a prefilled insulin pen, for one of four residents (R2) with records reviewed.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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:

R2's diagnoses included, cerebrovascular accident (CVA-stroke), chronic obstructive pulmonary disease (COPD) [a group of diseases that cause airflow blockage and breathing-related problems], high blood pressure, and osteoarthritis.

R2's Service Plan dated August 1, 2021, indicated R2 received medication management services, which included medication assist.

R2's medication orders dated April 28, 2022, included:
-Novolog 100 unit (U)/milliliter (ml) (insulin)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30728	A. BUILDING: _____ B. WING _____	06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HUMMINGBIRD	7704 COLE AVE MEADOWLANDS, MN 55765

(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
01760	Continued From page 40	01760		

subcutaneous (under the skin): 8 units at 8:00 a.m., 10 units at 12:00 p.m., and 5:00 p.m.
-Lantus 100 U/ml (long-acting insulin) 28 units at 8:00 a.m.

On June 14, 2021, at approximately 7:35 a.m., the surveyor observed ULP-F prepare the Lantus insulin pen (a multiple dose pen shaped injector device used for insulin administration) by placing the needle on to the end of the insulin pen and immediately dialed the pen to 28 units. ULP-F confirmed the dosage with licensed practical nurse (LPN)-D prior to raising R2's shirt up, cleaning an area on R2's upper left abdomen with an alcohol wipe and proceeded to inject the 28 units of Lantus insulin. The surveyor did not observe ULP-F prime the insulin pen prior to dialing up the prescribed Lantus insulin dose and administering 28 units of Lantus insulin to R2.

On June 14, 2022, at 1:20 p.m., ULP-F confirmed he did not prime (before drawing up dose you need to push out two units of medication to make sure the pen is working) the insulin pen prior to dialing the prescribed insulin dose ULP-F stated, "I used to, but now I just look in there and I can see the air leave."

On June 14, 2022, at 3:00 p.m., RN-C verified the ULP should have primed the insulin pen adding staff was trained on the correct procedure to give insulin injections.

The manufacturer's instructions for the use of Lantus insulin pen dated March 2020, directed for the insulin pen to be primed with two units prior to dialing the prescribed dosage. If no insulin comes out, repeat the test 2 more times. If there is still no insulin coming out, use a new needle and do the safety test again. In addition, never use the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30728	A. BUILDING: _____ B. WING _____	06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HUMMINGBIRD	7704 COLE AVE MEADOWLANDS, MN 55765

(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
01760	Continued From page 41 pen if no insulin comes out after using a second needle. The licensee's Insulin Pens policy updated July 30, 2018, confirmed all insulin pens, except Victoza, are to be held upright, dialed to 2 units, tap the cartridge holder gently to collect air bubbles to the top. Continue holding pen with the needle upwards, after removing the needle cover; push the dose knob until it stops. Hold the dose knob in and count slowly for 5 seconds. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01790 SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the	01790		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30728	A. BUILDING: _____ B. WING _____	06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HUMMINGBIRD	7704 COLE AVE MEADOWLANDS, MN 55765

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01790	Continued From page 42 unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication.	01790		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30728	A. BUILDING: _____ B. WING _____	06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HUMMINGBIRD	7704 COLE AVE MEADOWLANDS, MN 55765

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01790	Continued From page 43 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure two of two unlicensed personnel (ULP-E, ULP-F) were trained and had demonstrated competency to prepare and give medications for residents having unplanned time away. 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 June 13, 2022, at approximately 9:45 a.m., licensed assisted living director/owner (LALD/O)-A and licensed practical nurse/owner (LPN/O)-B confirmed all 11 residents at the establishment received medication management services ULP-E and ULP-F's records lacked evidence to indicate the registered nurse (RN) provided training and determined competency to prepare and administer medications to residents for unplanned times away. ULP-E was hired July 5, 2020, under the comprehensive home care license and began providing assisted living services on August 1, 2021. ULP-F was hired on April 5, 2021, under the	01790		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30728	A. BUILDING: _____ B. WING _____	06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HUMMINGBIRD	7704 COLE AVE MEADOWLANDS, MN 55765

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01790	Continued From page 44 comprehensive home care license and began providing assisted living services on August 1, 2021. On June 15, 2022, at 10:54 a.m., RN-C verified ULP-E, ULP-F, and all other ULP who administer medications, were not trained or had not demonstrated competency to prepare or give medications for any of the licensee's residents for unplanned times away. The licensee's Procedure For Delegation of Medications to be Given to Clients by Unlicensed staff for Clients Time Away From Home, dated 2017, confirmed only unlicensed staff that had been trained and have satisfactorily demonstrated competency would be assigned to place medications prepared by a pharmacist or a licensed nurse in the appropriate container for a leave of absence. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790		
01890 SS=E	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30728	A. BUILDING: _____ B. WING _____	06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HUMMINGBIRD	7704 COLE AVE MEADOWLANDS, MN 55765

(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 45	01890		

review, the licensee failed to ensure medications were maintained bearing the original prescription label with legible information including the expiration date for time sensitive medications for two of four residents (R5, R6).
This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).
The findings include:
On June 13, 2022, at approximately 10:35 a.m., the surveyor toured medication storage with licensed practical nurse (LPN)-D, including the locked medication cabinets in resident's rooms. LPN-D observed and confirmed the following:
R5
R 5's opened Symbicort 160/4.5 micrograms (mcg) (treatment of airflow obstruction) did not indicate the date the inhaler had been removed from the foil packaging and when the inhaler would expire.
R6
R 6 's opened Flovent 110 mcg (medication used to reduce swelling of the airways) did not indicate the date the inhaler had been removed from the foil packaging and when the inhaler would expire.
On June 14, 2022, at approximately 10:15 a.m., registered nurse (RN)-C verified medications should be dated when opened.
The manufacturer's instructions for Symbicort dated May 27, 2020, directed to discard the inhaler when the counter reached zero or three months after removed from foil pouch.
The manufacturer's instructions for Flovent HFA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30728	A. BUILDING: _____ B. WING _____	06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HUMMINGBIRD	7704 COLE AVE MEADOWLANDS, MN 55765

(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 46 dated December 2021, directed to discard the inhaler two months after opening. The licensee's Storage of Medication policy reviewed September 1, 2018, noted the proper storage of medication would include original prescription label with legible information stating the prescription number, name of drug, strength and quantity of drug, expiration date of time-dated drug, directions for use, client's name, prescriber's name, date of issue and the name and address of the licensed pharmacy that issued the medication. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on document review and interview, the licensee failed to provide a hazard vulnerability or safety risk assessment that had been performed on and around the property. This had the potential to directly affect all residents and staff.	02040		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30728	A. BUILDING: _____ B. WING _____	06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HUMMINGBIRD	7704 COLE AVE MEADOWLANDS, MN 55765

(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
02040	Continued From page 47 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On June 16, 2022, at 11:30 a.m., the LALD-A provided documents for review. Documents were reviewed by survey staff on June 16, 2022, between 11:30 a.m. and 12:00 p.m. A hazard vulnerability or safety risk assessment for the property was requested by survey staff but not provided. On June 16, 2022, at approximately 12:05 p.m., the LALD-A confirmed during an interview that the licensee had not completed a hazard vulnerability or safety risk assessment on and around the property. Survey staff explained that once an assessment was completed, hazards identified must be mitigated to protect residents from harm. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		
02110 SS=F	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the: (1) philosophy of how services are provided	02110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30728	A. BUILDING: _____ B. WING _____	06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HUMMINGBIRD	7704 COLE AVE MEADOWLANDS, MN 55765

(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
02110	Continued From page 48 based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure policies and procedures for assisted living with dementia care were provided to residents and the residents legal and designated representatives for all residents currently receiving services by the licensee.	02110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30728	A. BUILDING: _____ B. WING _____	06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HUMMINGBIRD	7704 COLE AVE MEADOWLANDS, MN 55765

(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
02110	Continued From page 49 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: The licensee was licensed as an Assisted Living with Dementia Care facility on August 1, 2021, with a capacity of 13 residents. On June 13, 2022, at 2:50 p.m., licensed practical nurse/owner (LPN/O)-B verified none of the residents and/or legal representatives received the inclusive list of dementia care policies and procedures as required at the time of move-in to the facility. LPN/O stated she was not aware of the requirement however the policies were confirmed to have been delevoped. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02110		
02140 SS=F	144G.83 Subd. 3 Supervising staff training Persons providing or overseeing staff training must have experience and knowledge in the care of individuals with dementia, including: (1) two years of work experience related to Alzheimer's disease or other dementias, or in health care, gerontology, or another related field; and(2) completion of training equivalent to the requirements in this section and successfully	02140		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30728	A. BUILDING: _____ B. WING _____	06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HUMMINGBIRD	7704 COLE AVE MEADOWLANDS, MN 55765

(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
02140	Continued From page 50 passing a skills competency or knowledge test required by the commissioner. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to designate a qualified person to oversee staff training in the care of individuals with dementia. This had the potential to affect all residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On June 13, 2022, at 9:45 a.m., licensed assisted living director /owner (LALD/O)-A confirmed no staff at the facility completed a competency or knowledge test required in dementia training that included all of the requirements.. Licensed practical nurse/owner (LPN/O)-B stated they did not think it was needed since training was done through Educare (online training system). LPN/O-B later stated she found the required training and was now aware of it. No further information was provided. TIME PERIOD TO CORRECT: Twenty-one (21) days	02140		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30728	A. BUILDING: _____ B. WING _____	06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HUMMINGBIRD	7704 COLE AVE MEADOWLANDS, MN 55765

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 51	02310		
02310 SS=G	144G.91 Subd. 4 Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards for one of one resident (R2) with side rails. In addition, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards with registered nurse (RN) follow up from an incident that was not done as required for one of one resident (R1), and for one of one resident (R3) who utilized a body alarm (personal alarm with a pull string that is to be attached to a person, when the string is pulled from the unit an alarm sounds) with records reviewed. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). This resulted in an immediate correction order on June 14, 2022, at 12:35 p.m. The findings include:	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30728	A. BUILDING: _____ B. WING _____	06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HUMMINGBIRD	7704 COLE AVE MEADOWLANDS, MN 55765

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 52 On June 14, 2022, at 6:55 a.m., the surveyor observed R2 laying in his bed on his back. R2's hospital bed had bilateral upper side rails that were secured to the bed. R2 stated he used the rails to help him get in and out of bed. R2's diagnoses included, cerebrovascular accident (CVA-stroke), chronic obstructive pulmonary disease (COPD) [a group of diseases that cause airflow blockage and breathing-related problems], high blood pressure, and osteoarthritis. R2's service plan dated August 1, 2021, indicated the resident received the following services: medication management, assistance with bathing/showering, dressing assistance, toileting/incontinence care, special dressing/ support hose, transfer assistance, catheter care, escorts, laundry and housekeeping. R2's Clinical Update Summary dated April 24, 2022, indicated R2 uses ½ bedrails for mobility. R2's Restraints: Side Rail Utilization Assessment dated January 25, 2022, included the purpose of the rails was for bed mobility/ positioning or to enable transfer. The assessment also included a statement that the resident and the resident's representative had been provided information on the risks and benefits of side rails. The assessment did not include actual measurements of the entrapment zones. On June 14, 2022, at 9: 55 a.m., RN-C stated R2 "likes those bedrails" and he used his side rails for mobility. RN-C stated side rail assessments were conducted at the time because "we decided to do them once a year."	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30728	A. BUILDING: _____ B. WING _____	06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HUMMINGBIRD	7704 COLE AVE MEADOWLANDS, MN 55765

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 53 On June 14, 2022, at 11:05 a.m., RN-C measured R2's side rail with the surveyor present. The side rail measured 16.5 inches tall by 3.5 inches wide, which was in compliance with FDA guidelines for side rails. Pressure was placed on the side rail and the side rail appeared to be securely fastened to the bed. The licensee's Assessing the Safety of Side Rails policy signed September 1, 2018, noted when the resident is utilizing side rails on a bed, the registered nurse (RN) would assess and evaluate what the resident's needs are and assess to determine if the resident can safely utilize the side rail/equipment and determine whether the side rail/equipment meets the FDA stands for side rails. The RN or licensed professional would provide education regarding side rail safety and risks including potential death due to falls, entrapment, and asphyxiation. educate the resident, and when appropriate. The policy refers to the 2006, Food and Drug Administration recommendations for reducing entrapments. The FDA identified seen "zones of entrapment" and recommended maximum dimensions for four of the zones. The March 10, 2006, FDA Side Rail Entrapment Zones and Dimensional Recommendations indicated to reduce the risk of entrapment, zone 1 (space between the rails), should be less than 4 and 3/4 inches. The FDA "A Guide to Bed Safety" revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30728	A. BUILDING: _____ B. WING _____	06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HUMMINGBIRD	7704 COLE AVE MEADOWLANDS, MN 55765

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 54	02310		

with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe".

No further information was provided.

The immediacy was removed as confirmed by documentation, observation and review by the surveyor and evaluation supervisor on June 14, 2022, at 2:02 p.m.; however, noncompliance remains at a level 3, isolated (G).

INCIDENT FOLLOW UP

R1's diagnoses included, schizophrenia, depression, cataracts, high blood pressure, diabetes, edema (swelling), chronic pain and anxiety.

R1's medications include aspirin daily for CVA prevention, anxiety medication, mood stabilizers, diuretic, pain medication, thyroid medication, cholesterol lowering medication, diabetes medication, and medication for constipation.

R1's Service Plan dated December 1, 2021, indicated the resident received the following services: ambulation/exercise, bathing/shower assist, dressing, escorts, grooming, housekeeping, laundry, meal try, medication assistance, medication setup, skin treatment, toileting/incontinence care, safety checks and vital sign monitoring to include pain.

R1's incident report dated May 30, 2022, at 10:55

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30728	A. BUILDING: _____ B. WING _____	06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HUMMINGBIRD	7704 COLE AVE MEADOWLANDS, MN 55765

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 55	02310		

p.m. indicated a fall:
Type of injury: Abrasion: "Resident stated he was turning onto his back while in bed and rolled off. Staff stated both PCA's (personal care attendant) were in resident's room 15 minutes prior and resident was on his back at that time. When staff entered room resident was lying on his side next to bed. Resident stated he scraped his head on the wall. 2.5 centimeters (cm) in diameter abrasion on the top of resident's head. Scant amount of bloody drainage. Area was cleansed, left open to air as there was no further drainage." Vital signs were taken, and he was assisted up by two staff with the aid of a gait belt (an assistive device which can be used to help safely transfer a person.)
Staff noted primary care provider (PCP) and RN would be called in the AM.

R1's Resident Notes included the following entries:
- occurrence dated May 31, 8:57 a.m., entered June 1, 2022, at 8:12 a.m., by LPN-D noted, resident denied pain besides the normal "my knees and shoulder hurt from when I lived at [name of facility], He also denied hitting his head from his recent fall. There is an abrasion noted on the top of his head that is scabbing over. Vitals were charted.
-occurrence dated May 31, 2022, 10:23 a.m., entered on June 14, 2022, at 10:24 a.m., by RN-C noted, notified of fall. Resident denies hitting head, No further follow up.
-occurrence dated June 1, 2022, 8:12 a.m., entered 8:14 a.m., by licensed practical nurse (LPN)-D noted, resident was up and about wheeling self in wheelchair. He ate 100% of breakfast, vitals were stable, and he denied pain at that time. Will continue to monitor.
-occurrence dated June 1, 2022, 9:21 a.m.,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30728	A. BUILDING: _____ B. WING _____	06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HUMMINGBIRD	7704 COLE AVE MEADOWLANDS, MN 55765

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 56	02310		

entered 10:25 a.m., June 5, 2022, by LPN/owner (LPN/O)-B noted, PCP and (RN)-C notified regarding fall. No injuries other than abrasion. Next physical therapy (PT) appointment is on Friday, June 3rd.

On June 14, 2022, at 9:50 a.m., surveyor interviewed RN-C regarding falls. RN-C confirmed she was to be notified "right away, within that shift." RN-C was asked if neuro checks [an evaluation of a person's nervous system) should have been done? "If injury" RN-C added she "looks at fall individually."

On June 16, 2022, at approximately 9:30 a.m., RN-C stated R2 denied hitting his head, the scrap had scabbed over, it was questioned if it happended.

The licensee's Reporting, Documentation and Reviewing incidents Involving Residents policy reviewed September 1, 2018, confirmed the staff present shall immediately contact the nurse in charge. The RN would document in the client's chart the detail of an incident involving the client and would document the follow-up actions that were taken. The RN would review the incident report with the home care director. Once they had assured that all necessary notifications had been completed, the RN would complete the review/comment/follow-up sections of the incident report.

BODY ALARM

R3's diagnoses included memory deficit, osteoarthritis, insomnia, depression anxiety, and fatigue.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30728	A. BUILDING: _____ B. WING _____	06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HUMMINGBIRD	7704 COLE AVE MEADOWLANDS, MN 55765

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 57 R3's record lacked evidence that the RN completed an assessment prior to the placement of a body alarm. On June 13, 2022, at approximately 11:30 a.m., the surveyor observed ULP-E assist R3 out of a reclining chair in the common's area. R3 had a body alarm attached to her. R3's Clinical Update Summary dated March 26, 2022, included "She has a body alarm on but during the night she was able to figure out how to detach it. She now has a bed alarm on when in bed as she continually was trying to get out of bed unassisted and has had falls or near falls. The bed alarm is working well. It goes off multiple times during the night but staff is able to reach her before she attempts to get up." On June 15, 2022, at 10:42 a.m., licensed practical nurse/owner (LPN/O)-B confirmed R3's record did not include an individual assessment for alarm use prior to using an alarm, "I was here until 9:00 p.m., last night I dug threw everything," The licensee's Assessment Regarding Safe Use of Assistive Devices policy reviewed September 1, 2018, indicated the RN's initial assessment and re-assessments would include an evaluation of a resident's ability to safely use any assistive device. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30728	A. BUILDING: _____ B. WING _____	06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HUMMINGBIRD	7704 COLE AVE MEADOWLANDS, MN 55765

(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
02350	Continued From page 58	02350		
02350 SS=D	144G.91 Subd. 7 Courteous treatment Residents have the right to be treated with courtesy and respect, and to have the resident's property treated with respect. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure residents are treated with dignity and respect for one of one resident (R3) observed wearing a gait belt (a device put on a person who has mobility issues which allows a caregiver a secure place to grab onto to transfer a person to different positions safety) while in the common's area. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R3's diagnoses included memory deficit, osteoarthritis, insomnia, depression anxiety, and fatigue. R3's service plan, signed October 1, 2021, indicated she received services for ambulation/exercise, transfer assistance, escorts, toileting/ incontinence care, bathing/showering assistance, dressing assistance, grooming assistance, medication administration, vital signs, and safety checks.	02350		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30728	A. BUILDING: _____ B. WING _____	06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HUMMINGBIRD	7704 COLE AVE MEADOWLANDS, MN 55765

(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
02350	Continued From page 59 On June 15, 2022, at 8:50 a.m., surveyor observed R3 in the common's area siting in a recliner with her eyes closed in a reclined position. There was a blanket covering R3's body, from her feet to just above her abdomen. A gait belt was securely fastened around R3's body just below her arm pits and across her chest. On June 15, 2022, at 9:01 a.m., surveyor and licensed practical nurse (LPN)-D went to where R3 was resting. LPN-D removed the gait belt from R3 stating "it [gait belt] should have been removed." R3's Service Chart Monthly task sign off form dated June 1, 2022, through June 13, 2022, indicated assist of one and gait belt with all transfers. On June 15, 2022, at 10:54 a.m., during an interview with registered nurse (RN)-C, licensed assisted living director/owner (LALD/O)-A, and LPN/O-B, regarding R3's gait belt, if it should have been removed? RN-C stated gait belts were to be "with the person", "on the person". How to Use A Gait Belt instructions dated June 6, 2022, indicated when done moving or walking with the person remove the gait belt. The Minnesota Bill of Rights for Assisted Living Residents dated May 16, 2021, indicates that residents have the right to be treated with courtesy and respect. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02350		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30728	A. BUILDING: _____ B. WING _____	06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HUMMINGBIRD	**7704 COLE AVE MEADOWLANDS, MN 55765**

(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

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

Type: Full
Date: *06/13/22*
Time: 10:30:00
Report: 7983221090

Food and Beverage Establishment Inspection Report

Location:
The Hummingbird
7704 Cole Ave
Meadowlands, MN55765
St. Louis County, 69

Establishment Info:
ID #: 0037508
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 2184272294
ID #:

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

The following orders were issued during this inspection.

3-500C Microbial Control: date marking

3-501.17B ** Priority 2 **

MN Rule 4626.0400B Mark the refrigerated, ready-to-eat, TCS food prepared and packaged in a processing plant and opened and held for more than 24 hours in the food establishment using an effective method to indicate the date by which the food must be consumed on the premises, sold, or discarded. The date must not exceed the manufacturer's use-by-date.

FOOD ITEMS IN THE SAMSUNG REFRIGERATOR/FREEZER WERE NOT MARKED WITH THE DATE THAT THE ORIGINAL PACKAGE WAS OPENED: 2/16/18: A PACKAGE OF BOLOGNA. 6/19/19: SHREDDED MOZZARELLA CHEESE. 6/13/22: SLICED AMERICAN CHEESE. SEE GENERAL COMMENT 2 BELOW.

Comply By: 02/16/18

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.

A METHOD FOR MEASURING THE SURFACE TEMPERATURE OF ITEMS WASHED IN THE WAREWASHING MACHINE (PLATE TEMPERATURE) WAS NOT PROVIDED. USE THE STICKER PROVIDED TO MEASURE THE PLATE TEMPERATURE, AND REPORT THE TEMPERATURE TO YOUR INSPECTOR.

Comply By: 06/13/22

7-100 Toxic Labeling

7-102.11 ** Priority 2 **

MN Rule 4626.1595 Clearly label all working containers used for storing poisonous or toxic materials from bulk supplies such as sanitizers and cleaners, with the common name of the product.

6/19/19, 6/13/22: OBSERVED A SPRAY BOTTLE CONTAINING A PINK LIQUID BELOW THE TWO-COMPARTMENT SINK IN THE KITCHEN. LABEL THE BOTTLE WITH ITS CONTENTS OR DISCARD CONTENTS.

Comply By: 06/19/19

2-100 Supervision

2-102.12DMN

MN Rule 4626.0033D Post the certified food protection manager certificate.

THE CERTIFIED FOOD PROTECTION MANAGER TOOK THE COURSE AND PASSED THE EXAM ON 5/10/2021; HOWEVER, THE MDH APPLICATION WAS NOT SUBMITTED. SEE GENERAL COMMENT 3 BELOW.

Comply By: 08/13/22

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

3-305.11A

MN Rule 4626.0300A Store all food in a clean, dry location; where it is not exposed to splash, dust or other contamination; and at least 6 inches above the floor.

POTATOES WERE STORED ON A SHELVING UNIT NEXT TO THE MOP SINK.

Comply By: 06/13/22

4-200 Equipment Design and Construction

4-201.11GMN

MN Rule 4626.0506G Discontinue serving TCS foods that are held for more than same-day service in an adult or child care center or boarding establishment or provide equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.

LEFTOVERS MIGHT BE KEPT FOR UP TO THREE DAYS.

Comply By: 06/13/22

5-200A Plumbing: approved materials/design

5-201.11B

MN Rule 4626.1040B Maintain the plumbing system in good repair.

THE CAP WAS MISSING FROM THE VACUUM BREAKER ON THE MOP SINK FAUCET.

Comply By: 06/27/22

Food and Equipment Temperatures

Process/Item: Refrigerator/Freezer
Temperature: 37 Degrees Fahrenheit - Location: Sliced cheese in the refrigerator compartment of the Samsung refrigerator/freezer.
Violation Issued: No

Process/Item: Refrigerator/Freezer
Temperature: N/A Degrees Fahrenheit - Location: Food in the freezer compartment of the Samsung refrigerator/freezer was frozen solid.
Violation Issued: No

Process/Item: Refrigerator/Freezer
Temperature: 39 Degrees Fahrenheit - Location: Raw shell egg in the refrigerator compartment of the Whirlpool refrigerator/freezer.
Violation Issued: No

Process/Item: Refrigerator/Freezer
Temperature: N/A Degrees Fahrenheit - Location: Food in the freezer compartment of the Whirlpool refrigerator/freezer was frozen solid.
Violation Issued: No

Process/Item: Cooking
Temperature: 170 Degrees Fahrenheit - Location: Chicken.
Violation Issued: No

Process/Item: Upright Freezer
Temperature: N/A Degrees Fahrenheit - Location: Food in the Frigidaire single-door upright freezer was frozen solid.
Violation Issued: No

Process/Item: Upright Freezer
Temperature: N/A Degrees Fahrenheit - Location: Food in the Montgomery Ward single-door upright freezer was frozen solid.
Violation Issued: No

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	0	3	4

==========

GENERAL COMMENTS:

1) Discussed excluding food employees ill with vomiting or diarrhea, eliminating bare hand contact with ready-to-eat food, and ensuring that in-house inspections of daily operations are conducted on a periodic basis to ensure that food safety policies and procedures are followed.

2) The following cheeses are exempt from date-marking: Hard cheeses containing not more than 39 percent moisture such as cheddar, gruyere, parmesan reggiano, and romano, as defined in Code of Federal Regulations, title 21, part 133 and semi-soft cheese containing more than 39 percent moisture, such as blue, edam, gorgonzola, gouda, and monterey jack, but not more than 50 percent moisture, as defined in Code of Federal Regulations, title 21, part 133.

3) An applicant for initial certification as a certified food protection manager (CFPM) shall complete a training course and pass an approved examination on the date taken. The examination must have been taken within six months directly preceding the application for certification.

4) Provided illness materials, and the following fact sheets: temperature/time requirements, date

marking, TCS food, and highly susceptible population.

5) Demonstrated how to calibrate a food thermometer. The digital food thermometer indicated a temperature of 31 degrees F. in an ice/water bath.

6) Meals are prepared the day of service; however, some leftovers are kept. The overnight staff prepares breakfast, the day staff prepares lunch and starts supper.

7) The Bosch dishwashing machine meets ANSI standard 184 for residential dishwashers.

==========

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 7983221090 of 06/13/22.

Certified Food Protection Manager: Juliana Class

Certification Number: Pending Expires: / /

Inspection report reviewed with person in charge and emailed.

Signed:_____ Signed: 7983

Michael Lindgren
Owner

651-201-4500
health.foodlodging@state.mn.us