DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered Via Email

May 27, 2022

Administrator
MTAI Sand Creek
5555 Westbrook Road
Golden Valley, MN 55422

RE: Event ID: Z0D522

Dear Administrator:

On May 23, 2022, the Minnesota Department(s) of Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me with any questions related to this letter.

Sincerely,

Kim Tyson

Kim Tyson, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-3831
Email: kim.tyson@state.mn.us

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Electronically Delivered Via Email

April 26, 2022

Administrator
MTAI Sand Creek
5555 Westbrook Road
Golden Valley, MN 55422

RE: Event ID: Z0D511

Dear Administrator:

On April 13, 2022, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for Intermediate Care Facilities for Individuals with Intellectual Disabilities participating in the Medicaid program. At the time of the survey, the survey team noted one or more deficiencies.

Federal certification deficiencies are delineated on the electonically delivered form CMS-2567 "Statement of Deficiencies and Plan of Correction". Certification deficiencies are listed on the left side of the form. The right side of the form is to be completed with your written plan for corrective action (PoC). Ordinarily, a provider will be expected to take the steps necessary to achieve compliance within 60 days of the exit interview.

A PoC for the deficiencies must be submitted within ten calendar days of your receipt of this letter. Your PoC must:

- The plan of correcting the specific deficiency. The plan should address the processes that led to the deficiency cited;
- The procedure for implementing the acceptable plan of correction for the specific deficiency cited;
- The monitoring procedure to ensure that the plan of correction is effective and that the specific deficiency cited remains corrected and/or in compliance with the regulatory requirements;
- The title of the person responsible for implementing the acceptable plan of correction; and,
- The date by which the correction will be completed

The PoC must be placed directly on the CMS-2567, signed and dated by the administrator or your authorized official. If possible, please type and return your plan of correction to ensure legibility. Please make a copy of the form for your records and return the original. Additional documentation may be attached to Form CMS-2567, if necessary.

Questions regarding all documents submitted as a response to the client care deficiencies (those preceded by an "W" tag) and emergency preparedness deficiencies (those preceded by an "E" tag), i.e., the plan of correction should be directed to:

Sarah Grebenc, Unit Supervisor
Metro A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: sarah.grebenc@state.mn.us
Phone: Mobile (651)238-8786

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Failure to submit an acceptable written plan of correction of federal deficiencies within ten calendar days may result in decertification and a loss of federal reimbursement.

Feel free to contact me with any questions related to this letter.

Sincerely,

Kim Tyson

Kim Tyson, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-3831
Email: kim.tyson@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24G438	A. BUILDING _____ B. WING _____	04/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MTAI SAND CREEK	**5555 WESTBROOK ROAD GOLDEN VALLEY, MN 55422**

(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) COMPLETION DATE
E 000	Initial Comments On April 11th - 13th, 2022, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
W 000	INITIAL COMMENTS A Focused Fundamental survey was conducted on April 11th - 13th, 2022. The facility, MTAI Sand Creek, was found NOT in compliance with the requirements of the Focused Fundamental Tags at 42 CFR 483 Subpart I, for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID).	W 000		
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observation, interview and document review, the facility failed to conduct the individual program plan with sufficient opportunities to support achievement of the desired goal for 2 of 3	W 249		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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W 249	Continued From page 1	W 249		

clients (C2 and C3) who had active treatment programs and also lacked documentation of programs offered and ran for the frequency assessed to be implemented.

Findings include:

C2's Emergency Data Form, revised 2/26/21, indicated C2 functioned at the severe level of intellectual disability.

In review of C2's Coordinated Service and Support Plan (CSSP) (last updated 12/11/21) indicated the following: "Everyday before dinner, [C2] will set her plate on the table, with two verbal cues or less, 75% of all trials over three consecutive months."

C2's program instructions directed staff to implement the following:

1. Before dinner, staff will tell [C2] that it is time for her to bring her plate to the table.
2. They will have [C2] come to the kitchen.
3. Staff will hand [C2] her empty plate and ask her to put it on her spot at the table.
4. Staff will praise [C2] for setting her plate on the table.

During dinner observations on 4/11/21, at 4:47 p.m. the qualified intellectual disability professional (QIDP) asked C1 if he wanted to set the table. After washing his hands, C1 placed silverware at each of the other clients' assigned table placements. C1 then poured glasses of milk for each client. In the kitchen direct support personnel (DSP)-A had dished clients' food on to plates then served each client. While C1 set the table and DSP-A dished the dinner meal, C2 sat

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W 249	Continued From page 2 in a living room recliner to wait for the dinner meal. Review of C2's active treatment program monthly data for her activity of daily living - (dinner plate placement) the program was documented as run for the following frequency: January 2022: 7 of 31 opportunities February 2022: 11 of 28 opportunities March 2022: 20 of 31 opportunities C3's Emergency Data Form, revised 5/27/21, indicated C3 functioned at the severe level of intellectual disability. In review of C3's Coordinated Service and Support Plan (CSSP) (last approved 4/10/18) indicated the following: "Everyday after work (or in the mornings on weekends), [C3] will participate in filling out his daily schedule, with three verbal cues or less, for 75% of all days over three consecutive months." C3's program instructions directed staff to implement the following: 1. Each day after [C3] arrives home from work or after breakfast on the weekends, staff will ask him if he is ready to fill out his schedule. 2. Staff will offer [C3] the icons needed to fill out the schedule with a choice of different activities along with necessary hygiene/daily living tasks. 3. During the shift, staff will direct [C3] to look at the schedule to determine what he should do next. 4. Once [C3] is done with a task, staff may need to prompt him to move the icon to the 'Done' column. 5. Staff will praise [C3] throughout the shift on	W 249		

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W 249	Continued From page 3 completing his schedule. During observations on 4/11/22, at 4:50 p.m. C3 was back from day program site and sat in the living room and slept. DSP-A was in the kitchen setting up for supper and DSP-B assisted other clients (cueing and/or physically assisting) with toileting, walking and other activities. At 3:30 p.m., C3 was offered and ate two cookies. From 3:30 p.m. until the dinner meal was served, at 5:20 p.m., C3 sat in the living room and either slept or watched TV. After dinner was completed, C3 returned to the living room and sat watching TV until 5:50 p.m. when DSP-A and DSP-C took all four clients on a van ride, and returned at 7:54 p.m. Upon return, C3 went to the bathroom, came back to the living room and sat and watched TV until 8:25 p.m. Review of C3's active treatment program monthly data for his Daily Activities - PM / Afternoon Shift, the program was documented as run for the following frequency: December 2021: 14 of 31 opportunities January 2022: 9 of 31 opportunities February 2022: 12 of 28 opportunities March 2022: 15 of 31 opportunities . In further review of C3's Coordinated Service and Support Plan (CSSP) (last approved 4/10/18) indicated the following: "Everyday, [C3] will remove his belt from his pants, with three verbal cues or less, 75% of opportunities for three consecutive months." C3's individual service program (ISP): Taking belt off: Everyday Before Bedtime directed staff to do the following:	W 249		

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W 249	Continued From page 4 1. While assisting [C3] in changing into his pajamas, staff will ask [C3] to take his belt out of his pants. 2. Staff will provide [C3] with verbal cues as needed to complete the task. 3. After initially asking [C3] to remove his belt, staff will count the number of cues it takes him to complete the task. 4. Staff will document how many cues it took for [C3] to complete the task. Review of C3's active treatment program monthly data for his Taking belt off: Everyday Before Bedtime, the program was documented as run for the following frequency: December 2021: 12 of 31 opportunities January 2022: 3 of 31 opportunities February 2022: 9 of 28 opportunities March 2022: 13 of 31 opportunities During interview on 4/13/22, at 9:30 a.m. qualified intellectual disability professional (QIDP) stated she had been educating staff on a monthly basis since July 2021 the importance of not only running, but documenting, all client programming assessed to improve each clients' abilities for self care and quality of life. QIDP stated not only was this important to be able to see if a client was improving their skills, it was important to the clients' families/guardians as well. The QIDP stated, without the programs being run and data collected, it was difficult to calculate progression in a client's ability The QIDP stated the facility did not have a policy for the implementation of active treatment plans.	W 249		
W 369	DRUG ADMINISTRATION CFR(s): 483.460(k)(2)	W 369		

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W 369	Continued From page 5 The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. This STANDARD is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure medications were administered in accordance with physician orders for 1 of 4 clients (C3) observed to receive medications. Findings include: C3's Emergency Data Form, revised 5/27/21, indicated C3 functioned at the severe level of intellectual disability. C3's Annual Physical (dated 1/2/22) included physician included orders for "omeprazole (used to treat stomach acid) 20 milligrams (mg) take 1 capsule by mouth daily. Take 1 hour before meal." During breakfast observation, on 4/12/21, at 6:58 a.m. C3 sat at the dining room table and waited for breakfast. Direct service professional (DSP)-D asked C3 if he wanted toast with his cereal. After C3 nodded, DSP-D placed a bowl of cereal with milk and a plate of toast in front of C3 and client began to eat. After C3 had completed his breakfast, DSP-D cued C3 that it was time for his morning medication and C3 needed to wash his hands. During medication observation, on 4/12/22 at 7:22 a.m. DSP-D set up C3's morning medications, which included C3's omeprazole 20 mg capsule. C3 took all medications.	W 369		

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W 369	Continued From page 6 A review of C3's medication administration records (MAR) for February 2022 and March 2022, it was noted that the medication recording system directed the facility staff to give the omeprazole at 7:00 am each day. During a telephone interview on 4/12/22, at 1:47 p.m. the facility's pharmacy consultant stated omeprazole needed to be taken on an empty stomach at least one hour before eating for it to effective. The pharmacy consultant stated to give omeprazole on a full stomach made the medication ineffective. During morning observation the following day, on 4/13/22, at 7:10 am. DSP-D took the computer to the kitchen to set up C3's morning medications. At that time, C3 sat in the living room and watched TV. Once the medications were set up by DSP-D, C3 was cued it was time for his medications and to come to the kitchen to wash his hands. After C3 had washed his hands, C3 sat at the dining room table and took his morning medications, which included omeprazole. Five minutes later, DSP-D poured C3 his morning cereal and client began to eat. During interview on 4/13/21, at 7:30 a.m. DSP-D (who worked the night staff) stated the night staff were responsible to set up and give morning medications for the clients in the facility. When asked about about C3's omeprazole, DSP-D stated and pointed to the MAR that C3's omeprazole was scheduled to be given each morning at 7:00 a.m.. DSP-D had not noticed the instructions to give the medication one hour before eating. In a telephone interview on 4/13/22, at 9:23 a.m.	W 369		

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W 369	Continued From page 7 licensed practical nurse (LPN)-A verified omeprazole should be given as physician ordered, one hour before eating. LPN-A stated that she and the facility would have to review C3's MAR, reschedule the medication and educate facility staff. A policy for medication order verification was requested by not received.	W 369		
W 488	DINING AREAS AND SERVICE CFR(s): 483.480(d)(4) The facility must assure that each client eats in a manner consistent with his or her developmental level. This STANDARD is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure clients were encouraged to participate in serving themselves their meal to the extent of their capability for 4 of 4 clients (C1, C2, C3 and C5) observed during meal time. Findings include: C1's Emergency Data Form, revised 3/23/20, indicated C1 functioned at the mild level of intellectual disability. C1's Intensive Support Self-Management Assessment (ISSA) last updated 11/22/21, indicated C1 had the ability to feed self and understood portion sizes. C2's Emergency Data Form, revised 3/31/22, indicated C2 functioned at the severe level of intellectual disability. C2's ISSA last updated 10/4/21, indicated that C2 was able to feed herself, however required supervision for diet compliance and taking other clients food.	W 488		

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W 488	Continued From page 8 C3's Emergency Data Form, revised 5/27/21, indicated C3 functioned at the severe level of intellectual disability. C3's ISSA last updated 10/4/21, indicated that C3 was able to feed himself, however required reminders to eat slowly. C5's Emergency Data Form, revised 6/07/21, indicated C3 functioned at the severe level of intellectual disability. C5's ISSA last updated 6/07/21, indicated that C3 was able to feed himself, however required reminders to eat slowly, and staff were to encourage C5 to assist with the pureeing of his meal items. During observations on 4/11/22, at 4:40 p.m. direct service professional (DSP)-A was observed in the kitchen preparing dinner. The dinner meal consisted of spaghetti on the stove with sauce, french cut green beans, slices of toasted / buttered bread and fresh cut papaya. DSP-A pureed the green beans and placed them in a 3 sectioned plate where pureed spaghetti was already dished for C5. On the counter next to C5's plate were three other regular plates, already dished with spaghetti and green beans. At 4:47 p.m. program manager asked C1 if he wished to set the table. After C1 finished setting the table, the remaining clients (C2, C3 and C5) were cued / brought to the dining room table with the pre-dished plates were served to each. DSP-A then went around the table with the bowl of freshly cut papaya and C1, C2 and C4 individually dished their servings with verbal cues while DSP-A held the bowl. During breakfast meal observations on 4/12/22, at 6:58 a.m. C3 sat at the dining room table and	W 488		

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W 488	Continued From page 9	W 488		

waited for his breakfast. After C3 received his medications from DSP-D, DSP-D then poured cold cereal in a 3 section deep plate, poured milk over the cereal and served C3. DSP-D then returned to the kitchen and retrieved 2 slices of toast from the toaster, buttered them and then served the toast to C3. At 7:03 a.m., C1 entered the kitchen, opened a cabinet, grabbed three round crackers and poured himself a glass of water, then returned to his room. At 7:49 DSP-B poured a bowl of cereal with milk and coffee, then placed in front C2, who began to eat. At 7:52 a.m. DSP-B went to the fridge and obtained already prepared lunch items and packed them in a lunch bag for C4 for day program. Then finally, at 7:58 a.m. DSP-B was observed to toast waffles and after pouring coffee, placed the meal items on the table for C1.

In an interview on 4/12/22, at 7:58 a.m. DSP-B stated staff know what each client wants for breakfast. When asked if the clients could toasted their own waffles or pour their own cereal or coffee, DSP-B stated C1, however, C2, C3 and C5 would need assistance from staff.

During a final meal observation on 4/13/22, at 6:52 a.m. DSP-B and DSP-D again poured cereal and milk, and toasted and plated waffles for C1, C2 and C4. DSP-B cooked oatmeal for C5, placed in his 3 sectioned plate/bowl and served this to C5.

In an interview 4/13/22, at 9:30 a.m. with program manager who was the qualified intellectual disability professional (QIDP) stated she noticed as well the evening meal on 4/11/22, was served with little participation from the clients. QIDP stated now with COVID restrictions decreasing,

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W 488	Continued From page 10 the facility staff should be encouraging clients to serve themselves. During a telephone interview on 4/13/21, at 11:00 a.m. during the exit conference, chief executive officer for intermediate care facilities / assisted living facilities (CEO) stated the corporate COVID policy still did not allow facilities to practice family dining. In review of the Centers of Medicare/Medicaid Services (CMS) Quality, Safety and Oversight (QSO) Memo QSO-21-14-ICF/IID & PRTF, revised 6/03/21, documented the following: Communal Activities and Dining Based on the status of COVID-19 infections in a facility, the facility should consider whether additional limitations on the following guidance should be applied in a specific care setting. While adhering to the recommended principles of COVID-19 infection prevention, facilities may permit communal activities and communal dining may occur. The CDC has provided additional guidance on group activities and group dining based on client/resident and staff vaccination status. For example, clients/residents who are fully vaccinated may dine and participate in activities together without face coverings or social distancing if all participating clients/residents are fully vaccinated; if unvaccinated clients/residents are present during communal dining or activities, then all clients/residents should use face coverings when not eating and unvaccinated clients/residents should physically distance from others. See the current CDC guidance Updated Healthcare Infection Prevention and Control	W 488		

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W 488	Continued From page 11 Recommendations in Response to COVID-19 Vaccination | CDC for information on communal activities and dining.	W 488		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	01561	A. BUILDING: _____ B. WING _____	04/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MTAI SAND CREEK	5555 WESTBROOK ROAD GOLDEN VALLEY, MN 55422

(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
5 000	Initial Comments In accordance with Minnesota Statute, section 144.56 and/or Minnesota Statute, section 144.653, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number or MN Statute indicated below. When a rule or statute contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. On April 11th - 13th, 2022 surveyors of this Department's staff visited the above provider to determine if compliance with the requirements of Minnesota Rules, Chapter 4665, requirements for Supervised Living Facilities (SLF) had been met. When corrections are completed, please sign and date on the bottom of the first page in the line marked with "Laboratory Director's or Provider/Supplier Representative's signature." Make a copy of these orders for your records and	5 000		

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5 000	Continued From page 1 email to Sarah Grebenc at sarah.grebenc@state.mn.us	5 000		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

April 26, 2022

Administrator
MTAI Sand Creek
5555 Westbrook Road
Golden Valley, MN 55422

Re: Project Number Event ID: ZOD511

Dear Administrator:

The above facility survey was completed on April 13, 2022 for the purpose of assessing compliance with Minnesota Department of Health Supervised Living Facility Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144.56.

Attached is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

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

Feel free to contact me with any questions related to this letter.

Sincerely,

Kim Tyson

Kim Tyson, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-3831
Email: kim.tyson@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24G438	A. BUILDING **01** B. WING _____	**04/12/2022**

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K 000	INITIAL COMMENTS FIRE SAFETY E-SCORE: 1.8 = SLOW An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 04/12/2022. At the time of this survey, MTAI Sand Creek was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.470(j), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 33 Existing Residential Board and Care. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 000	Continued From page 1 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145, or By e-mail to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. MTAI Sand Creek is a 1-story building with a full basement that was determined to be of Type V (111) construction. The facility is partially protected by and automatic fire sprinkler system and has a fire alarm system with smoke detection in resident rooms, corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a license capacity of 6 beds and had a census of 5 at the time of the survey. The requirement at 42 CFR, Subpart 483.470(j),	K 000		

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K 000	Continued From page 2 is NOT MET as evidenced by.	K 000		
K0345	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance 2012 EXISTING (Prompt) A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect the fire alarm system per NFPA 101 (2012 edition), Life Safety Code. section 9.6.1.3, and NFPA 72 (2010 edition), National Fire Alarm and Signaling Code, sections 14.4.5.3 through 14.4.5.3.3. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 04/12/2022 at 09:10 AM, it was revealed by a review of available documentation that the facility did not have a current record of the last smoke detector sensitivity testing being completed. An interview with Facility Director verified this deficiency finding at the time of discovery.	K0345		
K0711	Evacuation and Relocation Plan CFR(s): NFPA 101 Evacuation and Relocation Plan The administration of every resident board and	K0711		

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K0711	Continued From page 3 care facility shall have in effect and available to all supervisory personnel written copies of a plan for protecting all persons in the event of fire, for keeping persons in place, for evacuating persons to areas of refuge, and for evacuating person from the building when necessary. The plan shall include special staff response, including fire protection procedures needed to ensure the safety of any resident, and shall be amended or revised whenever any resident with unusual needs is admitted to the home. All employees shall be periodically instructed and kept informed with respect to their duties and responsibilities under the plan. Such instruction shall be reviewed by the staff not less than every two months. A copy of the plan shall be readily available at all times within the facility. All residents participating in the emergency plan shall be trained in the proper actions to be taken in the event of fire. Training shall include proper actions to be taken if the primary escape route is blocked. If the resident is given rehabilitation or habilitation training, training in fire prevention and the actions to be taken in the event of a fire shall be part of the training program. Residents shall be trained to assist each other in case of fire to the extent that their physical and mental abilities permit them to do so without additional personal risk. 32.7.1, 32.7.2, 33.7.1, 33.7.2 This STANDARD is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to update the evacuation and relocation plan per NFPA 101 (2012 edition), Life Safety Code, sections 33.7.1 through 33.7.1.3. This deficient finding could have a widespread impact on the residents within the facility.	K0711		

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K0711	Continued From page 4 Findings include: On 04/12/2022 at 09:20 AM, it was revealed by a review of available documentation that the facility emergency plan was last up-dated in 2007. This policy still referenced the 2000 edition of the Life Safety Code. An interview with Facility Director verified this | these deficiency finding at the time of discovery.	K0711		