STATE LICENSING COMPLIANCE REPORT

Report #: HL247809430C

Date Concluded: December 26, 2024

Name, Address, and County of Facility Investigated:
Amazing Love Assisted Living
5724 Bass Lake Road
Crystal MN, 55429
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Kris Detsch, RN
Special Investigator

The Minnesota Department of Health conducted a complaint investigation to determine compliance with state laws and rules governing the provision of care under Minnesota Statutes, Chapter 144G. The purpose of this complaint investigation was to review if facility policies and practices comply with applicable laws and rules. No maltreatment under Minnesota Statutes, Chapter 626 was alleged.

To view a copy of the correction orders, if any, please visit: https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html, or call 651-201-4201 to be provided a copy via mail or email. If you are viewing this report on the MDH website, please see the attached state form.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24780	A. BUILDING: _____ B. WING _____	11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMAZING LOVE ASSISTED LIVING	5724 BASS LAKE ROAD CRYSTAL, MN 55429

(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 An immediate correction order was identified on November 20, 2024, issued for SL24780016-0, tag identification 0780. 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: SL24780016-0 On November 18, 2024, through November 26, 2024, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 12 resident(s); 12 receiving services under the Assisted Living Facility license. The Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued related to HL247809430C, tag identification 470 and 1620. On November 20, 2024, an immediate correction order was issued for tag identification 0780.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 250 SS=F	144G.20 Subdivision 1 Conditions	0 250		

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0 250	Continued From page 1 (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 staff 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 staff; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4, or interferes with or impedes access by the Office of Ombudsman for Mental Health and Developmental Disabilities according to section 245.94, subdivision 1; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter;	0 250		

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0 250	Continued From page 2 (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. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on November 18, 2024, at 10:30 a.m., licensed assisted living	0 250		

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0 250	Continued From page 3 director (LALD)-A stated the licensee provided medication and treatment management services and they were familiar with the assisted living regulations. The licensee's Application for Assisted Living License signed on August 8, 2024, section titled Official Verification of Owner or Authorized Agent, (page five of the application), identified, I certify I have read and understand the following: [a check mark was placed before each of the following]: - I have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section] 144G.45, my building(s) must comply with subdivisions 1-3 of the section, as applicable section Laws 2020, 7th Spec. [special] Sess [session]., chpt. [chapter] 1. art. [article] 6, sect. 17. - I have read and fully understand Minn. Stat. sect. 144G.80, 144G.81. and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22, my building(s) must comply with these sections if applicable. - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G. - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659. - Reporting of Maltreatment of Vulnerable Adults. - Electronic Monitoring in Certain Facilities. - I understand pursuant to Minn. Stat. sect. 13.04 Rights of Subjects of Data, the Commissioner will use information provided in this application, which may include an in-person or telephone	0 250		

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0 250	Continued From page 4 conference, to determine if the applicant meets requirements for assisted living licensing. I understand I am not legally required to supply the requested information; however, failure to provide information or the submission of false or misleading information may delay the processing of my application or may be grounds for denying a license. I understand that information submitted to the commissioner in this application may, in some circumstances, be disclosed to the appropriate state, federal or local agency and law enforcement office to enhance investigative or enforcement efforts or further a public health protective process. Types of offices include Adult Protective Services, offices of the ombudsmen, health-licensing boards, Department of Human Services, county or city attorneys' offices, police, local or county public health offices. - I understand in accordance with Minn. Stat. sect. 144.051 Data Relating to Licensed and Registered Persons (opens in a new window), all data submitted on this application shall be classified as public information upon issuance of a provisional license or license. All data submitted are considered private until MDH issues a license. - I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659 governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. - I have examined this application and all attachments and checked the above boxes	0 250		

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0 250	Continued From page 5 indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct, and complete. I will notify MDH, in writing, of any changes to this information as required. - I attest to have all required policies and procedures of Minn. Stat. chapter 144G and Minn. Rules chapter 4659 in place upon licensure and to keep them current as applicable. Page six was electronically signed by owner (O)-J on August 8, 2024. An Assisted Living License was granted to licensee effective December 1, 2024, with an expiration date of November 30, 2025. As a result of this survey, the following orders were issued: 0470, 0480, 0650, 0680, 0720, 0780, 0790, 0800, 0810, 0830, 1060, 1370, 1380, 1470, 1620, 1640, 1760, 1880, 1910, 1940, and 1960, indicating the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.08 to 144G.95. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 250		
0 470 SS=I	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at	0 470		

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0 470	Continued From page 6 least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure their staffing plan was sufficient to meet the scheduled needs and reasonably foreseeable unscheduled needs of their resident population when the licensee provided care and services to thirteen residents who had significant mental health diagnoses and negative behaviors including substance abuse, physical aggression, stealing, property destruction, and suicidal ideation. This deficient practice had the potential to cause serious harm to all residents.	0 470		

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0 470	Continued From page 7 This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: RESIDENT NEEDS On November 18, 2024, at 7:44 a.m., the surveyor sent an email to the licensee to inform them of the surveyor would arrive to conduct the assisted living survey. The surveyor requested the licensee's resident roster. The licensee's undated resident roster indicated there were twelve residents receiving care and services by the licensee, but one resident was at the hospital. The roster also indicated: -thirteen residents required psychotropic medications (drugs that effect mind, emotions, behaviors); -two resident required insulin and blood glucose monitoring; -one resident required dialysis; -one resident required wound care; and -one resident required physical therapy. R1 R1 admitted to the licensee on January 30, 2024. R1's diagnoses included schizophrenia and psychotic disorder. R1's diagnoses included a history of methamphetamine abuse, sexual misconduct, and domestic assault via strangulation.	0 470		

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0 470	Continued From page 8 R1's care plan dated November 18, 2024, indicated he had a "Jarvis" order (court issued petition that mandates a resident receive antipsychotic medication without their consent) and required medication administration. The care plan indicated R1 also had a "Price Sheppard" (court ordered electroshock therapy (ECT) administered without the resident's consent) and received ECT. The care plan indicated R1 had a poor attention span and poor judgement. The care plan indicated R1 angered easily and was "uncontrollable" and resistive to redirection. The care plan indicated R1 violated sexual boundaries when he was anxious. The care plan indicated R1 was "uncontrollable" when physically aggressive and would damage property. The care plan indicated R1 had a history of smoking in his room. The care plan indicated R1 "lashed out" at others for no reason when he was psychotic. The care plan indicated R1 had a history of consumption of "meth" and other polysubstance drugs. The care plan indicated R1 was easily manipulated, persuaded, and exploited when out in the community to carry out "illegal acts". The care plan indicated staff members were to ensure R1 documented his whereabouts when out in the community. R2 R2 admitted to the licensee on January 26, 2024. R2's diagnoses included generalized anxiety disorder, major neurocognitive disorder, depressive disorder, hypertension, insulin dependent diabetes mellitus (IDDM), chronic obstructive pulmonary disease (COPD), kidney disease, alcoholism, coronary artery disease, pacemaker, and stent. R2's care plan dated September 27, 2024,	0 470		

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0 470	Continued From page 9 indicated R2 required mobility assistance from staff for all cases and mobility because he had a closed right ankle fracture and acute traumatic pain. The care plan indicated R2 was non-weight bearing on his right leg. R3 R3 admitted to the licensee on January 31, 2024, and discharged from the licensee on September 24, 2024. R3's diagnoses included schizophrenia and cluster B personality disorder. R3's diagnoses included a history of alcohol and marijuana use. R3's care plan, no date, indicated he had a "Jarvis" order from the court and required medication administration. The care plan indicated R3 had a poor attention span and poor judgement. The care plan indicated R3 smoked inside the home and was verbally aggressive with redirection. The care plan indicated R3 angered easily and was "uncontrollable" and resistive to re-direction. The care plan indicated R3 had anxiety and when he was anxious, he violated sexual boundaries. The care plan indicated R3 had physical aggression and would "lash out" at others for no reason and staff were required to keep objects that could cause harm away from him. The care plan indicated R3 used "meth" and other polysubstance drugs. The care plan indicated R3 was antisocial, narcissistic, and impulsive. The care plan indicated staff members needed to ensure to document R3's "whereabouts" when out in the community because he was easily manipulated, persuaded, and exploited to carry out improper and illegal acts. The care plan indicated staff members need to remind R3 he was not allowed at Holiday gas station because he shoplifted from them.	0 470		

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0 470	Continued From page 10 R4 R4 admitted to the licensee on April 12, 2023, for diagnoses including schizoaffective disorder, alcohol use disorder (severe), cocaine use disorder, and anxiety disorder. R4's care plan dated September 12, 2024, indicated she was on "civil commitment". The care plan indicated staff members needed to complete "rounds" every two hours and monitor R4 for anxiety, isolation, verbal aggression, and agitations. R5 R5 admitted to the licensee on March 3, 2023, for diagnoses including anxiety, left-sided weakness, muscle disorder, and Wolf-Parkinson-White (WPW) disease (rapid hear beat). R5's care plan dated September 25, 2024, indicated R5 required two staff "or more" staff members to safely transfer him out of bed. The care plan indicated R5 used a wheelchair and had a "deep-rooted" fear of falling. The care plan indicated R5 required total staff assistance for toileting and bathing cares. The care plan indicated R5 had a brain injury and had short-term memory loss. R6 R6 admitted to the licensee on April 12, 2023, for diagnoses including schizophrenia, catatonic schizophrenia, psychosis, anxiety, depression, and marijuana use. R6's care plan dated September 14, 2024, indicated staff members needed to monitor him for stealing, property destruction, verbal aggression and wandering. The care plan indicated R6 had a history of stealing from stores	0 470		

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0 470	Continued From page 11 and the nearby gas station. The care plan indicated R6 had a history of using other resident's credit/debit cards. The care plan indicated R6 was "very confrontational". The care plan indicated R6 was a "fire hazard" because he liked to smoke in his room and would hide in his closet when he smoked. The care plan indicated R6 had a history of setting the room on fire. R7 R7 admitted to the licensee on July 24, 2024, for diagnoses including delusional disorder, anxiety, mild neurocognitive impairment, paranoia, sexual misconduct, grandiosity, auditory hallucinations, and diabetes. R7's care plan dated September 26, 2024, indicated R7 had periods of disorientation and mild cognitive impairment. The care plan indicated R7 had a poor attention span and poor judgement. The care plan indicated R7 had paranoia and delusions. The care plan indicated staff members were to monitor R7 for inappropriate sexual behavior, soliciting, and disorderly conduct. R8 R8 admitted to the licensee on July 8, 2024, for diagnoses including end stage renal (kidney) disease, dialysis dependent, hemiplegia, right leg amputation, mood disorder, diabetes, depression, ineffective coping, and suicidal ideation. R8's care plan dated September 2, 2024, indicated R8 had physical mobility limitations due to amputation of his right leg. The care plan indicated R8 required dialysis three times weekly. The care plan indicated R8 had poor judgement and a decline in his cognition. The care plan indicated R8 suffered from post-traumatic stress	0 470		

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0 470	Continued From page 12 disorder (PTSD) and had a history of suicide ideation. The care plan indicated R8 was easily agitated and "uncontrollable" and resistive to re-direction. R9 R9 admitted to the licensee on July 14, 2017, for diagnoses including chronic undifferentiated schizophrenia, paranoid schizophrenia, psychosis, and psychotic disorder. R9's care plan dated September 14, 2024, indicated R9 was verbally aggressive and had disruptive behaviors. The care plan indicated R9 had sexually inappropriate behaviors. The care plan indicated R9 required 1 to 1 staff member support. R10 R10 admitted to the licensee on September 24, 2024, for diagnoses including schizophrenia and paranoid delusions. R10's care dated September 24, 2024, indicated he was uncontrollable when he was agitated. The care plan indicated R10's behavior was impulsive and unpredictable. The care plan indicated R10 was quick to anger and required staff members to keep potentially harmful objects away from him. The care plan indicated R10 would hit or punch others when he is paranoid and required staff to call law enforcement when he was out of control. The care plan indicated R10 required staff members to monitor him for alcohol and other chemical substance use. R11 R11 admitted to the licensee on April 6, 2023, for diagnoses including schizoaffective disorder, bipolar type, and violent tendency.	0 470		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 470	Continued From page 13 R11's care plan dated September 14, 2024, indicated R11 had poor impulse control when he was anxious. The care plan indicated R11 was uncontrollable when he was physically aggressive and damaged property. The care plan indicated R11 was physically aggressive and would "lash" out at others for no reason. The care plan indicated R11 required staff members to keep harmful objects away from him. The care plan indicated R11 had a history of polysubstance drug use including cocaine, meth, cannabis, crack/cocaine. The care plan lacked duration and frequency for staff members to monitor him for safety. R12 R12 admitted to the licensee on April 9, 2024, paranoid schizophrenia, psychosis, history of suicidal attempt, and a history of phenylcyclohexyl piperidine (PCP) and amphetamine/stimulant abuse. R12's care plan dated September 14, 2024, indicated R12 had a history of strangling staff. The care plan indicated staff members should believe R12 if he threatened to do so. The care plan indicated staff members should monitor for verbal aggression/disruption to others, anxiety, agitation, suicidal ideation, and physical aggression. The care plan indicated R12 required 8 hours of 1 to 1 activity (4 hours in the morning and early afternoon, and 4 hours in the afternoon/evening). Multiple areas in the care plan indicated R12 required 1 to 1 staff interaction. R13 R13 admitted to the licensee on March 15, 2019, and discharged from the licensee on November	0 470		

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	24780	A. BUILDING: _____ B. WING _____	11/26/2024

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0 470	Continued From page 14 8, 2024. R13's diagnoses included schizoaffective bipolar type disorder. R13's care plan dated October 3, 2024, indicated staff were to monitor R13 for self-injurious behavior and report any comments about suicide or suicidal ideation. The care plan indicated staff should contact a nurse if they observe any cuts, scratched, or skin changes. The care plan indicated R13 had hallucinations and delusions and had a history of elopements. The care plan indicated staff were to monitor R13 for substance abuse and R13 had a history of using cocaine, meth, and cannabis. The care plan indicated R13 engaged in dangerous behaviors to obtain drugs. The care plan indicated staff members were to monitor R13 for paranoia, wandering, anxiety, property damage, public urination, and agitation. The care plan indicated R13 required 1 to 1 staff interaction at times. The care plan indicated staff were to do "rounds" every one to two hours. RESPONSE TO RESIDENT EMERGENCIES R1 R1's incident reports completed by the licensee indicated: - September 11, 2024, no time, indicated staff found R1 smoking in his room and observed a piece of aluminum foil with black smoke residue on the back of his nightstand. The report indicated R1 said, "It was nothing", then took the foil downstairs. The report indicated later in the day, R1's sister told staff he took money from her purse. The report indicated staff notified the care team, primary physician, and "psych" physician by fax. The house manager (signature not legible) signed the incident report on September 13, 2024. - September 11, 2024, no time, indicated "another resident" told staff two months prior R1 said he	0 470		

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0 470	Continued From page 15 liked the resident (male/female not indicated) and wanted to have a relationship. The resident agreed and said, "we ended up having sex, but he almost raped me to death". The incident report failed to identify which resident reported this incident. The incident report indicated all protocols were followed and the "LAD" called (name unidentified) and left a voice message. The house manager (signature not legible) singed the incident report on September 17, 2024. - September 18, 2024, no time, indicated staff observed a piece of aluminum foil with black smoke residue on the back of it, with a cut-up bule straw that was melted at the tip on R1's nightstand. The report indicated staff removed the foil and straw. The report further indicated later in the day, R1 locked himself in another resident's room, and when he opened the door, staff observed another piece of foil in his hand with nothing in it. The incident report indicated the care team was notified. The house manager (signature not legible) signed the incident report on September 18, 2024. R1's progress notes indicated: -October 24, 2024, at 6:23 a.m., indicated a staff member found R1 smoking in his room. -October 24, 2024, at 4:07 p.m., indicated a staff member found R1 smoking in his room. -October 26, 2024, at 6:30 p.m., indicated a staff member found R1 smoking in his room. -November 2, 2024, at 8:10 a.m., indicated a staff member found R1 smoking "meth" in his room. The progress note indicated a staff member completed safety checks every two hours. R3 R3's incident reports completed by the licensee indicated on: -September 10, 2024, at 12:35 a.m., indicated a	0 470		

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0 470	Continued From page 16 staff member told R3 to turn the television volume done and he threatened to "smack" a staff member. The report indicated R3 manipulated the gas stove to light his cigarette and threatened to burn down the house along with staff members. The report indicated R3 continued to manipulate the gas stove and smoke and threatened to "smack" the staff member. The report indicated the staff member called licensed assisted living director (LALD)-A who then spoke to R3 (by phone), but R3 continued to smoke. The report indicated R3 threatened to burn the staff member with his cigarette. The report indicated LALD-A called law enforcement, but R3 left the licensee prior to their arrival. The report indicated law enforcement then returned to the licensee at 3:05 a.m., and told a staff member they found R3 and took him to jail because he assaulted law enforcement officers. R3's progress notes indicated: -August 25, 2024, at 12:04 a.m., indicated R3 was trying to fight with another resident and the other resident tried to run away and told R3 he did not want to fight. The progress notes indicated R3 kept "coming at the resident". The progress notes lack further detail about the altercation, but indicated the licensee called law enforcement. The progress notes indicated four minutes later, R3 was verbally abusive to staff, and the licensee called law enforcement and they took him to the hospital. -August 29, 2024, at 9:44 a.m., indicated R3 hit a resident on the head, hard, while the resident was sleeping on the couch. The progress notes indicated the licensee called law enforcement and they took the resident to the hospital. -September 10, 2024, at 8:35 a.m., indicated R3, "created a scene" beginning at 12:35 a.m., until about 2:50 a.m. The progress notes indicated the	0 470		

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0 470	Continued From page 17 licensee called law enforcement and they removed R3 from the home. The progress note lacked further information about R3's behavior, but indicated the licensee completed an incident report. STAFFING SCHEDULE On November 19, 2024, at 11:14 a.m., the surveyor observed the licensee's monthly staffing schedule dated November 1, 2024, through November 30, 2024. The schedule indicated the start times for the shifts varied. For example, the staffing schedule indicated: November 1: Morning shift: -one unlicensed personnel (ULP) 7:00 a.m. to 3:30 p.m. -one ULP 8:00 a.m. to 1:00 p.m. Evening shift: -two ULPs 3:00 p.m. to 11:30 p.m. Night shift: -one ULP 11:59 p.m. to 8:30 a.m. -one ULP 11:00 p.m. to 7:00 a.m. The schedule indicated there were fifteen days the licensee scheduled two ULPs for the morning shift and fifteen days the licensee scheduled three ULPs for the morning shift. The schedule indicated the licensee scheduled two ULPs for the evening and night shift. On November 19, 2024, at 1:38 p.m., the surveyor asked ULP-C to interview, however ULP-C was unavailable to interview. ULP-C said the ULP scheduled to work at 1:00 p.m., called in sick. On November 20, 2024, at 12:11 p.m., LALD-A said the staff member scheduled to work from 1:00 p.m. to 9:00 p.m., did not call-in sick yesterday (November 19, 2024). The ULP in	0 470		

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0 470	Continued From page 18 question told LALD-A one month prior she was unable to work. LALD-A said they had more than enough ULPs to meet their staffing plan. LALD-A acknowledged the staffing schedule should accurately reflect the staff members who were working. The licensee's uniform disclosure of assisted living services and amenities (UDALSA) dated August 8, 2024, indicated the licensee typically scheduled four unlicensed personnel (ULP) for the day shift, three for the evening shift, and two for the night shift. However, the UDALSA did not reflect the current staffing practices of the licensee. The licensee's undated staffing plan indicated there would be "2-3" direct care staff for the morning and evening shifts and two direct care staff working during the night shift. The staffing plan lacked evidence of evaluation of residents' needs to determine appropriate staffing levels. The staffing plan also lacked evidence it was reviewed twice a year. On November 19, 2024, at 2:30 p.m., ULP-C said the licensee was always fully staffed but the start times for the shifts vary somewhat. ULP-C said there was always a nurse at the licensee until 5:00 p.m., and after 5:00 p.m., there was a number to call. ULP-C said the nurse watched the computer and if you didn't chart something, she called the ULPs. ULP-C said there were two nurses on-call, and their numbers were "linked", so if you called, they responded immediately. ULP-C described the resident population as multi-cultural individuals who socialized amongst themselves. ULP-C said there were no residents who required mechanical lifts for transfers and only two residents who required wheelchairs for	0 470		

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0 470	Continued From page 19 mobility. ULP-C said, "once in a while" the residents could get "agitated" and when they do, the ULPs call the nurse and follow her instructions. ULP-C said there were five residents who smoked in their rooms. ULP-C said all residents receive safety checks every two hours, but they do not document the safety checks or what they observed during the safety checks. ULP-C said sometimes staff members have to call emergency services (911), but said it had been a long time ago, and nothing recently. ULP-C said she would know if other ULPs called 911 because those ULPs would tell her. ULP-C said she was unsure how she would know about resident substance abuse, but would report if the resident used substances, or if the resident acted unusual, she would report what she saw to the nurse. On November 20, 2024, at 10:33 a.m., ULP-G said there were always three staff members on the morning shift. ULP-G said the nurse was always there. ULP-G described the resident population as "quite good". ULP-G said he would call the nurse if a resident was aggressive, and the nurse would then direct him what to do. ULP-G said he called 911 by himself for one resident who was uncontrollable. ULP-G said their resident used "meth" or "something". ULP-G was unsure of the name of the resident, and when this occurred, but an incident report was completed. ULP-G said sometimes the residents fight and the licensee needed help from law enforcement. ULP-G said he completed safety checks every ten minutes or every one hour and documented them in the residents' progress notes. During the interview, the surveyor observed R1 turn on the stove and attempt to light a cigarette. Another ULP responded and assisted R1 away from the stove.	0 470		

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0 470	Continued From page 20 On November 20, 2024, at 12:11 p.m., LALD-A said the licensee "mainly" accepted residents with mental health diagnoses. The surveyor asked LALD-A if safety checks every two hours was sufficient to meet the needs for the resident population and LALD-A said the licensee's UDALSA indicated safety checks could be completed every two hours but if a resident was having a crisis, they might have to sit with them 1 to 1. LALD-A said the licensee did not want to change the UDALSA because they did not have the staff to accommodate further changes. LALD-A said the licensee called COPE (mobile crisis response) if there was a resident issue they could not handle. LALD-A acknowledged R1 smoked inside the home and said staff members needed to be diligent in their observation of him. LALD-A said R1's family members do not want him to receive 1 to 1 staff observation but did agree to hourly checks. The surveyor asked LALD-A how/if the licensee's staffing patterns keep the residents safe, but LALD-A did not acknowledge the staffing pattern, but explained how the residents' medications make a huge difference in the residents' behavior. LALD-A said if the residents do not take their medications, she makes their psychiatric physicians aware. LALD-A acknowledged the lack of documentation from ULPs regarding safety checks, but said they do document in the progress notes. LALD-A said law enforcement was only at the licensee once after R13 discharged (November 8, 2024). Law enforcement records dated June 29, 2024, through November 23, 2024, indicated law enforcement responded to the licensee fifty-three (53) times for instances such as disturbances, missing persons, sex crimes, accidents, assault, mental health problems, and a narcotic	0 470		

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0 470	Continued From page 21 complaint. On November 26, 2024, at 11:55 a.m., city office mental health coordinator (MHC)-H, said the licensee called law enforcement to enforce household rules, but law enforcement had no ability to enforce them. MHC-H said law enforcement received multiple calls for mental health crises and the licensee asked law enforcement to place residents on a "hold". MHC-C said the licensee knowingly accepted residents who the court placed on commitment, but then failed to monitor/ensure their safety. MHC-C said law enforcement received multiple calls regarding "missing" residents, however upon their arrival to the licensee, staff members failed to have looked for the residents. MHC-C said when law enforcement arrived to the licensee, the staff members appeared unaware of their residents' diagnoses or how to obtain information regarding them. MHC-H said law enforcement met with the licensee's leadership, but the leadership had been resistive in working with them. MHC-H said the licensee's written interventions for the management of the residents did not appear to be implemented from law enforcement's observations and interactions. MHC-H said since January 2024 through November 26, 2024, law enforcement received 149 calls regarding the licensee, and this was over three times the amount of calls from other licensed facilities. The licensee's Staffing policy dated August 1, 2021, indicated the licensee would develop and implement a staffing plan that ensures adequate staffing to meet the residents' needs at all times, including foreseeable needs. No further information was provided.	0 470		

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0 470	Continued From page 22 TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to	0 480		

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0 480	Continued From page 23 install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. 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, 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: Please refer to the document titled, Food and	0 480		

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0 480	Continued From page 24 Beverage Establishment Inspection Report (FBEIR) dated November 19, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 650 SS=F	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	0 650		

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0 650	Continued From page 25 review, the licensee failed to ensure the employee record contained the required content to include direct supervision of staff providing delegated tasks within 30 days for two of two unlicensed personnel ((ULP)-C, ULP-F) This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-C On November 18, 2024, at approximately 12:35 p.m., the surveyor observed ULP-C administering medications to R11 and R12. ULP-C was hired on January 12, 2024, and began providing assisted living services. ULP-C's employee record lacked documentation of a direct supervision of a delegated task by a registered nurse (RN) within 30 days of orientation. ULP-F ULP-F was hired on June 28, 2023, and began providing assisted living services. ULP-F's employee record lacked documentation of a direct supervision of a delegated task by a registered nurse (RN) within 30 days of orientation.	0 650		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 650	Continued From page 26 R2's record included a Medication Administration Record dated November 2024, indicating ULP-F had administered Humalog insulin to R2 at 7:30 a.m., on November 1, 2, 3, 4, 7, 8, 14, 15, and 18, 2024. On November 20, 2024, at 1:40 p.m., licensed assisted living director (LALD)-A stated she completed the 30-day supervision for staff members on delegated tasks. LALD-A stated she did not know why the documentation was missing from the files and she would have to look for it. The licensee's Supervision: Unlicensed Staff policy dated August 1, 2021, indicated direct supervision of home health aides perfuming delegated tasks will be provided within 30 days after the individual begins working for {licensee} and thereafter as needed based on performance, and that supervision would be documented in the employee's personnel file. The licensee's Personnel Records policy dated August 1, 2024, indicated documentation of supervision, as applicable, would be kept in the employee's personnel record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses	0 680		

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	24780	A. BUILDING: _____ B. WING _____	11/26/2024

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0 680	Continued From page 27 elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written emergency preparedness (EP) plan with all the required content. This had the potential to affect all residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	0 680		

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0 680	Continued From page 28 The findings include: On November 18, 2024, at approximately 3:45 p.m., the surveyor requested a copy of the licensee's emergency preparedness plan. On November 19, 2024, at approximately 4:00 p.m., the surveyor requested the licensee's emergency preparedness plan. Licensed assisted living director (LALD)-A stated the plan was not kept on site and that she would notify human resources to send the plan. On November 20, 2024, at approximately 2:20 p.m., the surveyor again requested the licensee's emergency preparedness plan. On November 25, 2024, at 3:32 p.m., the survey concluded without the surveyor receiving licensee's emergency preparedness plan. The licensee's Emergency Preparedness policy dated August 1, 2021, read "[Licensee] will have an identified plan in place to assure the safety and well being of residents and staff during periods of an emergency or disaster that disrupts services". No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 720 SS=F	144G.43 Subd. 2 Access to records The facility must ensure that the appropriate records are readily available to employees and contractors authorized to access the records. Resident records must be maintained in a	0 720		

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0 720	Continued From page 29 manner that allows for timely access, printing, or transmission of the records. The records must be made readily available to the commissioner upon request. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure that resident records were readily available for timely access to employees, vendors, and the commissioner authorized to access the records. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 was admitted on January 30, 2024, and began receiving assisted living services. R1's Service Plan dated January 31, 2024, indicated R1 received services including management and administration of medications. R2 was admitted on January 26, 2024, and began receiving assisted living services. R2's Service Plan dated January 26, 2024, indicated R2 received services including management and administration of medications. On November 18, 2024, at 3:45 p.m., the	0 720		

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0 720	Continued From page 30 surveyor requested signed prescriber orders and medication management assessments for R1 and R2. On November 19, 2024, at approximately 10:45 a.m., and 4:00 p.m., the surveyor again requested signed prescriber orders and medication management assessments for R1 and R2. On November 19, 2024, at approximately 4:00 p.m., licensed assisted living director (LALD)-A stated she would notify clinical nurse supervisor (CNS)-B to provide the requested information. On November 20, 2024, at 2:20 p.m., the surveyor again requested signed prescriber orders and medication management assessments for R1 and R2. Although requested, the surveyor did not receive signed prescriber orders and medication management assessments for R1 and R2 prior to the completion of the survey. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 720		
0 780 SS=I	144G.45 Subd. 2 (a) (1) Fire protection and physical environment 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	0 780		

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0 780	Continued From page 31 bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (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 comply with the current State Fire Code in Minnesota Rules, chapter 7511. The licensee failed to provide resident bedrooms with the minimum window opening meeting the minimum state standard for egress. The licensee failed to provide smoke alarms that functioned and were interconnected so that the actuation of one alarm caused all alarms in the dwelling unit to actuate. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that	0 780		

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0 780	Continued From page 32 has affected or has the potential to affect a large portion or all of the residents). The findings include: On November 20, 2024, from 10:30 a.m. to 11:00 a.m., the surveyor toured the facility with licensed assisted living director (LALD)-A. At 11:00 a.m. maintenance staff (M)-E joined the tour and LALD-A left the tour. At 12:15 p.m. M-E had an appointment to get to and LALD-A rejoined the tour at 1:00 p.m. to complete the tour of building 2. During the tour, the surveyor asked M-E and LALD-A to open the windows in the resident bedrooms for measurement. The noncompliant measurements were as follows: OCCUPIED SLEEPING ROOMS: Bedroom 2: Two windows measuring 19 1/2 inches clear width, 37 inches clear height, and 721 1/2 square inches total open area for each window. Bedroom 3: Two windows measuring 19 1/2 inches clear width, 37 inches clear height, and 721 1/2 square inches total open area for each window. Bedroom 4: Two windows measuring 19 1/2 inches clear width, 37 inches clear height, and 721 1/2 square inches total open area for each window. Bedroom 8: Two windows measuring 19 1/2 inches clear width, 48 inches clear height, and 936 square inches total open area for each window. Bedroom 9: Two windows measuring 19 1/2 inches clear width, 48 inches clear height, and 936 square inches total open area for each window. Bedroom 10: Two windows measuring 19 1/2 inches clear width, 48 inches clear height, and	0 780		

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0 780	Continued From page 33 936 square inches total open area for each window. Bedroom 11: Two windows measuring 19 1/2 inches clear width, 48 inches clear height, and 936 square inches total open area for each window. The openings in each resident bedroom were obstructed by the windowpane due to how the crank hardware and arm moved the window. In the closed position the clear widths measured over 20 inches, but when opened the clear opening widths were reduced significantly. M-E attempted to get a minimum 20-inch width when the windowpane was in different positions of open, but at no point could the clear opening meet the 20-inch minimum width. The windows in bedrooms 2, 3, 4, 8, 9, 10, and 11 did not meet the minimum requirements for opening width. Egress windows in existing sleeping rooms must have a minimum openable width of 20 inches and minimum openable height of 20 inches with no less than 648 square inches total of openable area (4.5 square feet) for the window. At least one window in each bedroom in a state-licensed facility must meet the minimum state fire code standard for an egress window to be a complying bedroom for resident occupancy. On November 20, 2024, the surveyor explained to LALD-A that an immediate correction order was issued for the above findings. LALD-A stated they did not realize the windows were not compliant and would get them replaced as soon as possible.	0 780		

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0 780	Continued From page 34 TIME PERIOD FOR CORRECTION: Immediate. On the same facility tour on November 20, 2024, the following was observed: SMOKE ALARMS LALD-A initiated a test of the smoke alarms throughout the two houses. Upon testing, it was found that the smoke alarms in House 1 were not interconnected in bedroom 11 and the upper level living room. Upon testing, it was found that the smoke alarms in House 2 in bedrooms 1, 2, 4, and 5 did not sound when tested. None of the smoke alarms in House 2 were interconnected. SMOKING AND CIGARETTE DISPOSAL A resident was observed attempting to light a cigarette on the gas stove in the kitchen while surveyors were conducting an interview with LALD-A in the adjacent room. A staff member stopped the resident and told him that he was not allowed to smoke inside. Resident sleeping room 5 on the main level was being used as a cigarette rolling station and had ash and burn marks on the top of the night stand adjacent to the bed. There was also a black cup on the night stand that was used as an ashtray. Resident sleeping rooms 10 and 11 on the upper level had ash and burn marks on the top the night stands adjacent to the beds. Used cigarette smoking materials are required to be discarded in appropriate containers in the designated, exterior smoking areas. There were appropriate containers provided for discarding the	0 780		

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0 780	Continued From page 35 used cigarette butts outside. On November 20, 2024, at 3:30 p.m. LALD-A stated they did not know that the smoke alarms were not fully interconnected in House 1. LALD-A also stated that House 2 was used to isolate residents who were ill with Covid-19. House 2 was currently unoccupied and LALD-A did not know the smoke alarms were not working or interconnected. LALD-A also stated they suspected some of the residents were smoking in the sleeping rooms, but never caught them. 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 deficient condition had the potential to affect all staff, residents, and visitors.	0 790		

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0 790	Continued From page 36 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 November 20, 2024, from 10:30 a.m. to 11:00 a.m., the surveyor toured the facility with licensed assisted living director (LALD)-A. At 11:00 a.m. maintenance staff (M)-E joined the tour and LALD-A left the tour. At 12:15 p.m. M-E had an appointment to get to and LALD-A rejoined the tour at 1:00 p.m. to complete the tour of building 2. The portable fire extinguishers throughout the two buildings lacked records to show monthly visual inspections were completed. Documentation is required to demonstrate fire extinguishers have been inspected by facility personnel monthly, and annually replaced with a new extinguisher or serviced annually by a certified technician. The fire extinguisher in the laundry room of house 1 was 1-A:10-BC rated. All fire extinguishers in the facility must meet the minimum requirement of 2-A:10-B:C. On November 20, 2024, at 3:30 p.m., the surveyor explained to LALD-A that the portable fire extinguishers must be provided annual certification tags and also monthly visual inspections or "quick checks" of each extinguisher by their employees to ensure all	0 790		

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0 790	Continued From page 37 portable extinguishers are readily available, fully charged, and operable at their designated location with no obvious physical damage or condition to the extinguisher that would prevent their operation when needed. LALD-A stated they did not know monthly inspections were required. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and	0 800		

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0 800	Continued From page 38 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 November 20, 2024, from 10:30 a.m. to 11:00 a.m., the surveyor toured the facility with licensed assisted living director (LALD)-A. At 11:00 a.m. maintenance staff (M)-E joined the tour and LALD-A left the tour. At 12:15 p.m. M-E had an appointment to get to and LALD-A rejoined the tour at 1:00 p.m. to complete the tour of building 2. HOUSE ONE: - The window hardware in bedrooms 2, 3, 4, and 5 was not maintained. The casement style windows were missing the crank or the crank interior was stripped and unable to open the winodw. M-E replaced the crank in each bedroom at the time of discovery. - The kitchen floor tiles were cracked throughout the whole kitchen. - The bathroom adjacent to the laundry room had significant cracking in the shower floor insert. It was also broken around the drain area. The window crank to the operable window was missing. - The bathroom across the hall from the laundry room was missing the window crank and the wood trim was missing from the door. HOUSE TWO: - The upper-level bathroom ceiling had water damage by window.	0 800		

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0 800	Continued From page 39 - The window in bedroom 4 was not able to close fully once it was open. The closet door was falling off the track. - The wood trim was missing at kitchen door jamb. - The lower-level bathroom had holes in the ceiling around the plumbing work. The window is open to structure above. On November 20, 2024, at 3:30 p.m., LALD-A stated they would correct the above-listed deficiencies. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 800		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff 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) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter.	0 810		

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0 810	Continued From page 40 (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 staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required training and drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On November 20, 2024, at 2:30 p.m., the surveyor observed the fire safety and evacuation plan was not located in a central location for all staff accessibility.	0 810		

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	24780	A. BUILDING: _____ B. WING _____	11/26/2024

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0 810	Continued From page 41 On November 20, 2024, at 3:30 p.m., LALD-A stated they did not have the fire safety and evacuation plan (FSEP) on site and would have a member of their human resources (HR) team email the FSEP, fire safety and evacuation training, and evacuation drills for the facility to the surveyor by noon on November 21, 2024. On November 22, 2024, the surveyor received an email with the FSEP and drill logs attached. FIRE SAFETY AND EVACUATION PLAN: The licensee's FSEP, titled "Fire Safety", dated August 1, 2021, failed to include the following: The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The provided FSEP was from a third-party provider and had not been updated to the specific facility. The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. The FSEP included standard resident evacuation procedures but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan included instructions to evacuate residents but did not include any procedures for assisting residents during evacuation nor did it include instructions for staff to follow in case of relocation.	0 810		

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0 810	Continued From page 42 TRAINING: The licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. LALD-A lacked documentation showing any training was offered or training was scheduled for a future date for residents on the fire safety and evacuation plan. Provided documentation included "Fire Drill Reports", dated August 26, 2022, August 23, 2022, November 02, 2022, July 31, 2024, and September 25, 2024, included a statement at the top which read, "I have been educated on how to safely evacuate this building." with signatures below the statement. The fire drill reports were dated for the same days as the licensee recorded fire drills being completed. There was no complete record provided that all staff received the required training. Training must be provided to all staff on the fire safety and evacuation plan and shall be conducted separately from fire evacuation drills. DRILLS: The licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month. Record review of licensee's evacuation drill log, titled "Emergency Drill Reporting Form", indicated evacuation drills were conducted on April 10, 2023, April 28, 2023, July 6, 2023, September 28, 2023, November 4, 2023, January 6, 2024, March 6, 2024, May 2, 2024, and July 31, 2024. Emergency Drill Reporting Form lacked times or indication of shift for each documented evacuation drill. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	0 810		

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0 810	Continued From page 43 (21) days.	0 810		
0 830 SS=F	144G.45 Subd. 3 Local laws apply Assisted living facilities shall comply with all applicable state and local governing laws, regulations, standards, ordinances, and codes for fire safety, building, and zoning requirements, except a facility with a licensed resident capacity of six or fewer is exempt from rental licensing regulations imposed by any town, municipality, or county. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to follow applicable state and local laws, regulations, standards, ordinances, and codes related to smoking for three of three residents (R1, R3, 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) 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 November 18, 2024, during a facility tour at approximately 1:00 p.m., the surveyor observed multiple cigarettes burns on the bedside stand in bedroom #10 (belonging to R1) along with multiple cigarette butts and a cigarette lighter.	0 830		

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0 830	Continued From page 44 The surveyor noted the room smelled of cigarette smoke. The surveyor was accompanied by licensed assisted living director (LALD)-A and clinical nurse supervisor (CNS)-B who both stated the room smelled of cigarette smoke. LALD-A removed the cigarette lighter from the resident room and stated, "he knows he is not supposed to be doing that". LALD-A stated they were having problems with R1's family providing smoking materials to him, and a care conference had been held with the family to discuss smoking issues earlier in the day. On November 20, 2024, at approximately 10:30 a.m., the surveyor observed R1 lighting a cigarette from a gas stove in the kitchen. A staff member intervened and removed R1 from the area. The Minnesota Clean Indoor Air Act (MCIAA) amendment effective on September 7, 2023, noted smoking was prohibited in health care facilities and clinics. In addition, an indoor area meant a space between a floor and a ceiling that is at least half enclosed by walls, doorways, or windows (opened or closed) around the perimeter. A wall included retractable dividers, garage doors, plastic sheeting or any other temporary or permanent physical barrier. Minnesota State Statute 144.414 Prohibitions; Subdivision 3 dated 2024, indicated under a section titled Health care facilities and clinics: (a) Smoking was prohibited in any area of a hospital, health care clinic, doctor's office, licensed residential facility for children, or other health care-related facility, except that a patient or resident in a nursing home, boarding care facility, or licensed residential facility for adults may smoke in a designated separate, enclosed room	0 830		

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0 830	Continued From page 45 maintained in accordance with applicable state and federal laws. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) Days	0 830		
01060 SS=D	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to:	01060		

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01060	Continued From page 46 (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with required content for an emergency relocation for one of three residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R3 was admitted on February 1, 2024, and began receiving assisted living services. R3's Service Plan dated February 1, 2024, indicated R3's services included mealtime assistance and medication and behavioral management.	01060		

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01060	Continued From page 47 R3's record included Progress Notes that indicated R3 had been taken to the hospital on August 29, 2024, and had returned from the hospital on September 5, 2004. R3's Progress Note dated September 10, 2024, at 8:35 a.m., indicated R3 had been removed from the facility by the Crystal police department. R3's record included a Discharge Summary dated September 20, 2024. On November 19, 2024, at approximately 4:00 p.m., licensed assisted living director (LALD)-A stated they did not provide an emergency relocation notice to the resident's legal representative or notify the Office of Ombudsman for Long-Term Care when R3 was admitted to the hospital on August 29, 2024, or on September 10, 2024. The licensee's Discharge and Transfer of Residents policy dated August 1, 2021, indicated in the event of emergency relocation, the licensee would provide a written notice of Emergency Relocation to the following: -the resident; -the resident's legal representative; -the resident's designated representative; -the resident's case manager as applicable; and -if the resident has been relocated and not returned to [licensee] within four (4) days, the Office of the Ombudsman for Long-Term Care. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01060		

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01370	Continued From page 48	01370		
01370 SS=E	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and	01370		

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01370	Continued From page 49 (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency evaluations included all the required training for two of two unlicensed personnel (ULP-C, ULP-F). 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 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: ULP-C ULP-C was hired on December 18, 2023, and began providing assisted living services. ULP-C's employee record lacked the required competencies for appropriate and safe techniques in personal hygiene and grooming including: -hair care and bathing; -care of teeth, gums, and oral prosthetic devices; -care and use of hearing aids; and -dressing and assisting with toileting. ULP-F ULP-F was hired on June 28, 2023, and began providing assisted living services. ULP-F's employee record lacked the required	01370		

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01370	Continued From page 50 competencies for appropriate and safe techniques in personal hygiene and grooming including: -hair care and bathing; -care of teeth, gums, and oral prosthetic devices; -care and use of hearing aids; and -dressing and assisting with toileting On November 20, 2024, at approximately 12:38 p.m., licensed assisted living director (LALD)-A stated they were unaware that training competencies were incomplete and would contact clinical nurse supervisor (CNS)-B to see if they had been done. The licensee's Staff Competency policy dated August 1, 2021, indicated staff would be required to pass a written examination and demonstrate competence in appropriate and safe techniques in personal hygiene and grooming, including hair care and bathing; care of teeth, gums and oral prosthetic devised; care and use of hearing aids; and dressing and assisting with toileting. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		
01380 SS=E	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other	01380		

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01380	Continued From page 51 observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and/or competencies were completed and documented two of two unlicensed personnel ((ULP)-C, ULP-F). 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 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: ULP-C ULP-C was hired on January 12, 2024, and began providing assisted living services. ULP-C's employee record lacked evidence of completed training and/or competency testing for the following: -basic knowledge of body functioning, injuries, or other observed changes that must be reported to	01380		

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01380	Continued From page 52 appropriate personnel; and -recognizing physical, emotional, cognitive, and developmental needs of the resident. ULP-F ULP-F was hired on June 28, 2023, and began providing assisted living services. ULP-F's employee record lacked evidence of completed training and/or competency testing for the following: -basic knowledge of body functioning, injuries, or other observed changes that must be reported to appropriate personnel; and -recognizing physical, emotional, cognitive, and developmental needs of the resident. On November 20, 2024, at approximately 12:38 p.m., licensed assisted living director (LALD)-A stated they were unaware that training competencies were incomplete and would contact clinical nurse supervisor (CNS)-B to see if they had been done. The licensee's Staff Competency policy dated August 1, 2021, indicated staff would complete the following training prior to working for [licensee]: -basic knowledge of body functioning and changes in body function, injuries, or other reportable changes; and'-recognizing physical, emotional, cognitive, and developmental needs of the resident. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380		

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01470	Continued From page 53	01470		
01470 SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the staff member will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this	01470		

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01470	Continued From page 54 subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employees received orientation to include all required content for three of three employees (manager (MGR)-D, unlicensed personnel (ULP)-C, ULP-F). 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:	01470		

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01470	Continued From page 55 MDR-D MGR-D was hired on December 18, 2023, and began providing assisted living services. MGR-D's employee record lacked documentation of the following required orientation topics: -an overview of assisted living statutes; -an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; -handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; and -a review of the types of assisted living services the employee will be providing and the facility's category of licensure. ULP-C ULP-C was hired on January 12, 2024, and began providing assisted living services. ULP-C's employee record lacked documentation of the following required orientation topics: -an overview of assisted living statutes; An introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; and -a review of the types of assisted living services the employee will be providing and the facility's category of licensure. ULP-F ULP-F was hired on June 28, 2023, and began providing assisted living services. ULP-F's employee record lacked documentation of the following required orientation topics:	01470		

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01470	Continued From page 56 -an overview of assisted living statutes; -an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; -handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; and -a review of the types of assisted living services the employee will be providing and the facility's category of licensure. On November 20, 2024, at approximately 12:10 p.m., licensed assisted living director (LALD)-A stated they were unaware of the required content for orientation and did not know there were components missing from the orientation program. The licensee's Staff Orientation and Education policy dated August 1, 2021, indicated orientation topics would include: -an overview of Minnesota Assisted Living Statute 144g and Minnesota Rules Chapter 4659; -introduction to and review of the organization's policies and procedures related to the provision of assisted living services by the individual staff person; -grievance policy/process, including reports to the Office of Health Facility Complaints; and -the types of assisted living services the employee will be providing based on the Uniform Checklist Disclosure of Services and the organization's category of licensure. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		

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01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) documented ongoing resident monitoring and reassessment of smoking behavior and new interventions when documented interventions failed for three of three residents (R1, R3, R6). In addition, the licensee failed to include all areas required on the uniform assessment tool for three of three residents (R1, R2, R3) and failed to ensure comprehensive nursing assessments	01620		

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01620	Continued From page 58 were completed within the required 90-day time frame for two of three residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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: SMOKING ASSESSMENT R1 R1 admitted to the licensee on January 30, 2024. R1's diagnoses included schizophrenia, psychotic disorder, a history of methamphetamine abuse, sexual misconduct, and domestic assault via strangulation. R1's service plan dated January 31, 2024, indicated R1 required assistance with dressing, grooming, meals, and medication. The service plan indicated R1 required staff to remind him not to go into other resident rooms uninvited. The service plan indicated R1 required staff to check on him every one hour. The licensee updated R1's service plan on November 18, 2024, and indicated R1 had a history of smoking in his room and staff were to ensure this did not occur. R1's care plan dated November 18, 2024, indicated he had a "Jarvis" order (court issued petition that mandates a resident receive antipsychotic medication without their consent) and required medication administration. The care plan indicated R1 also had a "Price Sheppard"	01620		

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01620	Continued From page 59 (court ordered electroshock therapy (ECT) administered without the resident's consent) and received ECT. The care plan indicated R1 had a poor attention span and poor judgement. The care plan indicated R1 angered easily and was "uncontrollable" and resistive to redirection. The care plan indicated R1 violated sexual boundaries when he was anxious. The care plan indicated R1 was "uncontrollable" when physically aggressive and would damage property. The care plan indicated R1 had a history of smoking in his room. The care plan indicated R1 "lashed out" at others for no reason when he was psychotic. The care plan indicated R1 had a history of consumption of "meth" and other polysubstance drugs. The care plan indicated R1 was easily manipulated, persuaded, and exploited when out in the community to carry out "illegal acts". The care plan indicated staff members were to ensure R1 documented his whereabouts when out in the community. R1's unsigned, undated Smoking Risk Assessment indicated R1's refusal to adhere to facility smoking policies. R1's Progress Notes dated October 15, 2024, through November 18, 2024, indicated R1 was observed by staff smoking in his bedroom on October 17, 2024, and November 3, 4, 8, 14, and 16, 2024. R1's record included Conference Meeting Notes on [R1] dated November 18, 2024, indicating family and resident noncompliance with the smoking agreement. R3 R3 admitted to the licensee on January 31, 2024, and discharged from the licensee on September 24, 2024. R3's diagnoses included schizophrenia	01620		

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01620	Continued From page 60 and cluster B personality disorder. R3's diagnoses included a history of alcohol and marijuana use. R3's service plan dated February 1, 2024, indicated R3 was independent with mobility, but required assistance with dressing and grooming. The service plan indicated he required behavior monitoring daily. R3's care plan, no date, indicated he had poor attention span, and poor judgement. The care plan indicated R3 smoked inside the home and gets verbally aggressive when staff correct him. The care plan also indicated R3 did "drugs" when outside the facility. The care plan indicated R3 angered easily when agitated and violated sexual boundaries when he was anxious. The care plan indicated R3 had verbal outbursts when he was "manic" and required staff to keep objects away from him which could potentially cause harm. The care plan indicated R3 "lashed out" at others for no reason when he was psychotic. The care plan indicated R3 had a history of "meth" consumption, and other polysubstance drugs. The care plan indicated R3 was antisocial, narcissistic, and impulsive. Because R3's care plan was not dated, and handwritten, it is unclear when the licensee identified R3's behaviors, and interventions. R3's Smoking Assessment dated February 1, 2024, indicated R3 smoked in non-designated smoking areas and refused to adhere to licensee's smoking policies. R6 R6 was admitted on September 23, 2019, under the licensee's former comprehensive license and began receiving assisted living services on	01620		

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01620	Continued From page 61 August 1, 2024. R6's diagnoses include schizophrenia, psychosis, and anxiety. R6's Service Plan dated February 29, 2024, indicated R6's services included mealtime assistance, medication management, and behavioral management. R6's Care Plan revised September 14, 2024, indicated R6 smoked in the closet of his room and had a history of setting his room on fire. R1, R3, and R6's records lacked documentation of ongoing reassessment and monitoring and new interventions when unsafe smoking behavior continued and current interventions were insufficient. On November 19, 2024, at approximately 2:30 p.m., unlicensed personnel (ULP)-C stated there were five residents who smoked in the house and were on safety checks every two hours. ULP-C stated safety checks were not documented. On November 20, 2024, at approximately 12:25 p.m., LALD-A stated they try to manage indoor smoking issues through safety checks every two hours and R1 had recently been increased to hourly safety checks. UNIFROM ASSESSMENT TOOL/TIMING OF ASSESSMENTS R1 R1's nursing assessment dated April 1, 2024, indicated the assessment was a routine 90-day assessment. The assessment was a two-page abbreviated assessment and did not indicate the registered nurse (RN) reviewed the most recent comprehensive assessment. The assessment failed to include the following assessment tool	01620		

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01620	Continued From page 62 elements: -sleep schedule; -dietary needs; -social needs; -spiritual preferences; -advanced health directives; -toileting pattern; -dressing, bathing, grooming, and personal hygiene; -mobility status; -eating, dental status, oral care; -housework; -laundry; -transportation; -review of medical and nursing diagnoses; -allergies; -current memory, orientation, confusion, and decision-making status; -nutritional and hydration status; -nursing needs, including potential to receive nursing-delegated services; -risk indicators; -smoking, including the ability to smoke without causing burns or injury to the resident or others or damage to property; and -alcohol and drug use. R1's record included consecutive assessments completed on April 1, 2024, and July 1, 2024, indicated 91 days passed between assessments. R1's consecutive assessments completed on July 1, 2024, and October 30, 2024, indicated 121 days passed between assessments. R2 R2 admitted to the licensee on January 26, 2024. R2's diagnoses included generalized anxiety disorder, major neurocognitive disorder, depressive disorder, hypertension, insulin	01620		

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01620	Continued From page 63 dependent diabetes mellitus (IDDM), chronic obstructive pulmonary disease (COPD), kidney disease, alcoholism, coronary artery disease, pacemaker, and stent. R2's service plan dated January 26, 2024, indicated he was a fall risk and used a wheelchair and a walker. R2's care plan dated September 27, 2024, indicated R2 required mobility assistance from staff for all cases and mobility because he had a closed right ankle fracture and acute traumatic pain. The care plan indicated R2 was non-weight bearing on his right leg. R2's record included consecutive assessments completed on February 16, 2024, and July 3, 2024, indicated 137 days passed between assessments. R2's nurse reassessment dated September 27, 2024, failed to include the signature of the RN. The assessment was a two-page abbreviated assessment and did not indicate the RN reviewed the most recent comprehensive assessment. The assessment failed to include the following assessment tool elements: -sleep schedule; -dietary needs; -social needs; -spiritual preferences; -advanced health directives; -toileting pattern; -dressing, bathing, grooming, and personal hygiene; -eating, dental status, oral care; -housework; -laundry; -transportation;	01620		

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01620	Continued From page 64 -review of medical and nursing diagnoses; -allergies; -current memory, orientation, confusion, and decision-making status; -nutritional and hydration status; -nursing needs, including potential to receive nursing-delegated services; -risk indicators; -smoking, including the ability to smoke without causing burns or injury to the resident or others or damage to property; and -alcohol and drug use. R3 R3's nursing assessment dated July 1, 2024, indicated the assessment was a routine 90-day assessment. The assessment was a two-page abbreviated assessment and did not indicate the RN reviewed the most recent comprehensive assessment. The assessment failed to include the following assessment tool elements: -sleep schedule; -dietary needs; -social needs; -spiritual preferences; -advanced health directives; -toileting pattern; -dressing, bathing, grooming, and personal hygiene; -eating, dental status, oral care; -housework; -laundry; -transportation; -review of medical and nursing diagnoses; -allergies; -current memory, orientation, confusion, and decision-making status; -nutritional and hydration status; -nursing needs, including potential to receive nursing-delegated services;	01620		

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01620	Continued From page 65 -risk indicators; -smoking, including the ability to smoke without causing burns or injury to the resident or others or damage to property; and -alcohol and drug use. On November 20, 2024, at 12:11 p.m., licensed assisted living director (LALD)-A acknowledged the licensee's universal assessment form lacked required content per Minnesota Administrative Rule 4659.0150. On November 20, 2024, at 12:43 p.m., LALD-A said she was unaware the nursing assessments for R1 and R2 exceeded the 90-day requirement. LALD-A acknowledged the nursing assessments should not exceed the 90-day time frame. The licensee's Assessment and Reassessment policy dated August 1, 2021, indicated a RN would complete ongoing resident assessments, not to exceed 90 days. The licensee's Comprehensive Nursing Assessment policy dated August 1, 2021, indicated a RN would complete comprehensive assessments for all residents admitted to the licensee, utilizing a uniform assessment tool. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01620		
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	01640		

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01640	Continued From page 66 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 and the Office of Ombudsman for Mental Health and Developmental Disabilities. (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 interview and record review, the licensee failed to ensure the current service plan included a signature or other authentication by the licensee and by the resident or resident's representative to document agreement of services to be provided for three of three residents (R1, 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).	01640		

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01640	Continued From page 67 The findings include: R1 R1 was admitted on January 30, 2024, and began receiving assisted living services. R1's Service Plan dated January 31, 2024, indicated R1's services included assistance with dressing, grooming, meals, behavior management, hourly safety checks, and medication administration. R2 R2 was admitted January 26, 2024, and began receiving assisted living services. R2's Service Plan dated January 26, 2024, indicated R2 received services including mealtime assistance, behavioral management, and medication management. R3 R3 was admitted on January 31, 2024, and began receiving assisted living services. R3's Service Plan dated February 1, 2024, indicated R3 received services including mealtime assistance, behavior management, and medication administration. R1, R2, and R3's Service Plans lacked authentication by the resident or representative indicating agreement with the services to be provided. On November 20, 2024, at 12:43 p.m., licensed assisted living director (LALD)-A stated they add revisions to the existing service plan and note the dates of update under the care plan review. LALD-A stated they do not have the resident or	01640		

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01640	Continued From page 68 resident representatives sign the service plan when developed or revised and that they verbally inform the resident representatives of the changes. The licensee's Service Plan policy dated August 1, 2021, read the initial service plan and any revisions are signed by a representative from [licensee]and the resident or resident's representative, indicating agreement with the services to be provided. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01760 SS=F	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document medication	01760		

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	24780	A. BUILDING: _____ B. WING _____	11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMAZING LOVE ASSISTED LIVING	5724 BASS LAKE ROAD CRYSTAL, MN 55429

(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 69 administration in residents' records for two of two residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 number or all the residents). The findings include: R1 R1 was admitted on January 30, 2024, and began receiving assisted living services. R1's Service Plan dated January 31, 2024, indicated R1's services included medication management and administration. R1's record included a Medication Administration Record (MAR) dated November 2024. The MAR indicated the licensee failed to document administration or refusal of the following medications between November 1, 2024, through November 17, 2024: -olanzapine 10 milligrams (mg); take one (1) tablet by mouth (PO) three times daily. The licensee failed to document the 7:30 a.m. dose 1 out of 17 days, failed to document the 12:00 p.m. dose two (2) out of 17 days, and failed to document the 8:30 p.m. dose 2 out of 17 days. - polyethylene glycol; take 17 grams PO two times daily. The licensee failed to document the 7:30 a.m. dose 1 out of 17 days, and failed to document the 7:30 p.m. dose 1 of 17 days. -senna 8.6 mg tablets; take 2 tablets PO twice daily. The licensee failed to document the 7:30	01760		

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01760	Continued From page 70 a.m. dose 1 of 17 days and failed to document the 7:30 p.m. dose 1 of 17 days. R2 R2 was admitted on January 26, 2024, and began receiving assisted living services. R2's Service Plan dated January 26, 2024, indicated R2's services included medication management and administration. R2's record included a MAR dated November 2024. The MAR indicated the licensee failed to document administration or refusal of the following medications between November 1, 2024, and November 17, 2024: -gabapentin 300 mg capsules; Take 1 capsule PO every 12 hours. The licensee failed to document at 7:30 p.m. on 1 of 17 days. -Humalog insulin 100 units (U)/milliliter (ml); Inject 10 U under skin three times daily. The licensee failed to document the 2:00 p.m. dose 14 out of 17 days, and failed to document the 8:30 p.m. dose 4 out of 17 days. -hydrocortisone 1% cream; apply topically four times daily for skin irritation; the licensee failed to document the 8:00 a.m. dose on 1 out of 17 days, failed to document the 12:00 p.m. dose 14 out of 17 days, failed to document the 4:00 p.m. dose 17 out of 17 days, and failed to document the 8:00 p.m. dose on 5 out of 14 days. -Lantus insulin 100 U/ml; inject 14 U under the skin at bedtime. The licensee failed to document the 7:30 p.m. dose on 3 of 17 days. -metformin 500 mg tablets; Take 1 tablet PO two times daily. The licensee failed to document the 7:30 p.m. dose on 1 of 17 days. -methocarbamol 500 mg tablet; take 1 tablet PO twice daily. The licensee failed to document the 7:30 p.m. dose on 1 of 17 days.	01760		

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01760	Continued From page 71 -metoprolol tartrate 25 mg tablet; take 1 tablet twice daily. The licensee failed to document the 7:30 p.m. dose on 1 of 17 days. -mirtazapine 7.5 mg tablet; take 1 tablet PO at bedtime. The licensee failed to document the 7:30 p.m. dose on 1 of 17 days. -Prerservision Areds capsules; take 1 capsule PO twice daily. The licensee failed to document the 7:30 p.m. dose on 1 of 17 days. -ranolazine 500 mg tablets; take one tablet PO twice daily. The licensee failed to document the 7:30 p.m. dose on 1 of 17 days; and -rosuvastatin 40 mg tablet; take 1 tablet PO daily. The licensee failed to document the 7:30 a.m. dose on 3 of 17 days. On November 20, 2024, at 12:55 p.m., licensed assisted living director (LALD)-A stated they were unaware that medication administration or refusals were not being documented in the MARs. LALD-A stated that staff may document refusals in the progress notes. The licensee's Medication Documentation policy dated August 1, 2021, read "if the administration of one or more medications was not completed, staff will document the following: a. The reason why the medication was not administered; b. Follow up procedures to meet the resident's needs in compliance with the Medication Management Plan; c. Appropriate notification to RN supervisor or other persons as instructed regarding missed dosages; and d. Medication Error report, if appropriate." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	01760		

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01760	Continued From page 72 days	01760		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to store all prescription medications according to the manufacturer's directions. 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: On November 19, 2024, at approximately 12:55 p.m., the surveyor observed a countertop refrigerator in the locked medication room. The refrigerator did not have a locking mechanism. Contents of the refrigerator included insulin for R2 (two boxes of Humalog insulin, one full and one containing an unused insulin pen and one unopened box of Lantus insulin. The refrigerator contents also included an opened package of beef jerky sticks. The floor of the refrigerator had standing water. The refrigerator contained a	01880		

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01880	Continued From page 73 thermometer which was not functioning. On November 19, 2024, at approximately 1:00 p.m., licensed assisted living director (LALD)-A removed the food item and the box of Lantus insulin from the refrigerator. LALD-A stated the food should not be stored in the refrigerator. LALD-A stated they did not monitor the temperature of the refrigerator and had been told that it was not necessary. LALD-A verified the thermometer was not working and they removed it from the refrigerator. LALD-A stated they would replace the thermometer and begin monitoring refrigerator temperatures. The Lantus package insert developed by Sanofi-Aventis and revised June 2023, indicated the following instructions for storage: -store unused Lantus between 2° to 8° Celsius (C) (36° to 46° Fahrenheit (F)) in a refrigerator; -do not freeze. Discard Lantus if it has been frozen; -protect Lantus from direct heat or light; -Lantus that has been opened (refrigerator or room temperature) should be discarded after 28 days. The Humalog Kwik-Pen® Instructions for Use developed by Eli Lilly Company and revised July 2023, indicated the following instructions: - store unused pens in a refrigerator at 36° to 46° F (between 2° to 8° C); -do not freeze insulin and do not use if frozen; and -unused pens may be used until the expiration date printed on the label if the pen has been kept in the refrigerator. The licensee's Storage/Control of Medications policy dated August 1, 2021, indicated all	01880		

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01880	Continued From page 74 prescription drugs would be stored securely locked in substantially constructed compartments according to the manufacturer's directions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document in the resident's record the disposition of the medications as required for one of one resident (R3) upon	01910		

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01910	Continued From page 75 discharge. 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 admitted to the facility on January 31, 2024, and discharged on September 24, 2024. R3's diagnoses included schizophrenia, personality disorder, and a history of alcohol and marijuana abuse. R3's Service Plan dated February 1, 2024, indicated R3's services included behavior monitoring and medication management and administration. R3's record included a Medication Administration Record dated August 2024, which indicated R3 had been administered the following medications: -fluoxetine 10 milligrams (mg) by mouth (PO) daily; -haloperidol 5 mg tablets; two tablets PO twice daily; -olanzapine 20 mg PO at bedtime; and -trazodone 100 mg PO at bedtime. R3's record lacked documentation of disposition of medications at the time of discharge. On November 19, 2024, at approximately 4:00	01910		

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01910	Continued From page 76 p.m., the surveyor requested documentation of medication disposition for R3. Licensed assisted living director (LALD)-A stated they would request the information from clinical nurse supervisor (CNS)-B. LALD-A stated "he [R3] always refused his medication". No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and	01940		

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01940	Continued From page 77 therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On November 18, 2024, at approximately 2:00 p.m., the surveyor observed unlicensed personnel (ULP)-C assist R2 with a blood sugar check by handing him supplies as he performed a finger stick and checked his blood sugar. R2 was admitted on January 26, 2024, and began receiving assisted living services. R2's Service Plan dated January 26, 2024, indicated R2's services included behavioral monitoring, medication management and administration, and wound care provided by a	01940		

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01940	Continued From page 78 third party. R2's service plan did not include blood glucose monitoring as a service received by R2. R2's undated Treatment Plan indicated R2 received blood glucose monitoring. R2's treatment plan lacked the following required content: -documentation of specific resident instructions related to the treatment or therapy administration; and -any resident specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. On November 19, 2024, at approximately 11:00 a.m., licensed assisted living director (LALD)-A stated they were unaware R2's treatment plan was not complete and would notify clinical nurse supervisor (CNS)-B. The licensee's Treatment and Therapy Management policy dated August 1, 2021, indicated the registered nurse (RN) would prepare an individualized treatment or therapy management plan for each resident receiving ordered or prescribed treatments or therapy services which would address the following: -type of service to be provided; -procedures for documenting treatments or therapies- -procedures for monitoring treatments or therapies to precent possible complications or adverse reactions; -identification of treatment or therapy tasks delegated to unlicensed personnel; and -procedures for notifying the RN when a problem arises related to the treatment or therapy service.	01940		

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01940	Continued From page 79 No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure documentation of administration of or the reason why a treatment was not administered and any follow-up procedures that were provided for one of one resident (R2) receiving treatments. 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).	01960		

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01960	Continued From page 80 The findings include: On November 18, 2024, at approximately 2:00 p.m., the surveyor observed unlicensed personnel (ULP)-C assist R2 with a blood sugar check by handing him supplies as he performed a finger stick and checked his blood sugar. R2 was admitted on January 26, 2024, and began receiving assisted living services. R2's Service Plan dated January 26, 2024, indicated blood glucose monitoring was not included in services received by R2. R2's record included an undated Treatment Management Plan which indicated R2 received blood glucose checks at a frequency per MD order. R2's record included a Daily Blood Sugar Tracker with blood glucose results recorded between November 1, 2024, through November 18, 2024. R2's Daily Blood Sugar Tracker lacked documentation of a blood sugar result for November 3, 4, 6, and 8, 2024. The surveyor requested R2's prescriber orders on November 18, 2024, at 3:45 p.m., November 19, 2024, at 10:45 a.m., November 19, 2024, at 4:00 p.m., and November 20, 2024, at 2:20 p.m. The surveyor did not receive prescriber orders for R2 prior to the close of the survey on November 26, 2024. On November 20, 2024, licensed assisted living director (LALD)-A stated R2's orders for blood glucose checks had recently been decreased from three times daily to twice daily. LALD-A stated they were unaware the blood glucose	01960		

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01960	Continued From page 81 results were not documented as ordered and stated they would check with clinical nurse supervisor (CNS)-B. The licensee's Treatment and Therapy Management policy dated August 1, 2021, read "when a treatment or therapy is not administered as ordered or prescribed, staff will document the reason why it was not administered, and any follow-up procedures provided to meet the resident's needs as documented in the care plan or treatment plan or as ordered by the authorized prescriber. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960		