STATE LICENSING COMPLIANCE REPORT

Report #: HL373783434C

Date Concluded: February 28, 2023

Name, Address, and County of Facility Investigated:
Care Partners Homecare
3508 83rd Avenue North
Brooklyn Park, MN 55443
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Peggy Boeck, 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
	37378	A. BUILDING: _____ B. WING _____	C 03/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PARTNERS HOMECARE LLC	3508 83RD AVENUE NORTH BROOKLYN CENTER, MN 55443

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0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: #HL373783434C On February 21, 2023 through March 1, 2023, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 3 residents receiving services under the provider's Assisted Living license. The following immediate correction orders are issued for #HL373783434C, tag identification 0470, 0680, and 0770. The licensee was notified of the immediate orders on February 21, 2023, at 11:30 a.m. The immediacy was removed on March 1, 2023, however, scope and severity remains at an I. The following correction order is issued for	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	

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0 000	Continued From page 1 #HL373783434C, tag identification tag identification 0480. Additional information received from the licensee was added to previously written orders, 0470, 0680, and 0770.	0 000		
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 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	0 470		

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0 470	Continued From page 2 by: Based on observation, interview, and document review, the licensee failed to ensure adequate staffing for three of three residents (R1, R2, and R3) reviewed. The facility failed to ensure prompt response to emergent situations or to ensure the resident's basic needs were met, when the licensee scheduled one staff on the night shift with two residents (R2 and R3) who required a full mechanical lift with two staff for transfers, and a wheelchair dependent resident (R1) who required staff to carry his wheelchair to another level of the home in order to exit. The facility was notified of the immediacy on February 21, 2023. The immediacy was removed on March 1, 2023, however, scope and severity remains at an I. 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). Findings include: R1 admitted to the facility on November 23, 2021, due to diagnoses that included history of psychosis, cauda equina syndrome, and osteoarthritis. R1 lived in a room on the upper level of the facility. R1's individual abuse prevention plan (IAPP) dated November 15, 2022, indicated R1 required a wheelchair and did not ambulate.	0 470	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	

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0 470	Continued From page 3 R2 admitted to the facility on February 2, 2023, due to diagnoses that included chronic kidney disease, morbid obesity, schizoaffective disorder, congestive heart failure, and traumatic brain injury. R2 lived in a room on the lower level of the facility. R2's IAPP dated February 1, 2023, indicated R2 required a wheelchair and did not ambulate. R3 admitted to the facility on July 26, 2022, due to diagnoses that included schizophrenia, heart failure, chronic obstructive pulmonary disease, chronic respiratory failure, and neurocognitive impairment. R3 lived in a room on the lower level of the facility. R3 's IAPP dated July 29, 2022, indicated R2 required a wheelchair and did not ambulate. During an observation on February 21, 2023, from 6:30 a.m. to 7:00 a.m., the investigator observed one staff in the facility to provide cares for the three residents. During a tour of the facility on February 21, 2023, at 7:50 a.m. with clinical nurse supervisor (CNS)-D, the investigator observed the lower-level exit which opened onto a patio that was covered with ice and connected to a walkway up a hill to the driveway, which connected with the street. The investigator observed the walkway also covered with ice, rendering it impassable due to the angle and the ice. This was the only exit for residents living on the lower level and there was not a street at the back of the facility. During an interview on February 21, 2023, at 6:30 a.m. unlicensed personnel (ULP)-A stated she	0 470		

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0 470	Continued From page 4 was the only staff who worked the night shift, 11:00 p.m. to 7:00 a.m., and did not get the residents out of bed on the night shift. ULP-A stated if there was an emergency and the residents needed to get out of bed, she would call the nurse for help or call 911. ULP-A stated R2 and R3 required two staff with a mechanical lift for transfers out of bed. During an interview on February 21, 2023, at 6:45 a.m. R1 stated there was only one staff who worked on the night shift, and R1 stated he often saw the night staff sleeping on the couch on the main floor. R1 stated he had concerns for the two residents on the lower level [R2 and R3] if there was an emergency at night, as the one staff could never get them out. R1 stated R2 and R3 needed two staff to transfer them using a mechanical lift. R1 stated the lower-level exit was impassable due to ice buildup that the licensee did not remove. (The investigator observed and confirmed the ice completely covered the sidewalk from the upper-level driveway down the sidewalk to the back exit door which prevented anyone from walking on it.) During interview on February 21, 2023, at 7:15 a.m. R2 stated he feared he would burn up with the house if there was a fire because there are not enough staff to get him out of bed, much less out of the building. During interview on February 21, 2023, at 7:30 a.m. R3 stated staff did not get him up because he needed two staff with the mechanical lift to get out of bed and there was only one staff at night. During an interview on February 21, 2023, at 7:45 a.m., CNS-D stated the full mechanical lift the facility used for transferring R2 and R3 required	0 470		

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0 470	Continued From page 5 two staff to operate. CNS-D stated one staff was scheduled on night shift, 11:00 p.m. to 7:00 a.m., and if there was an emergency "staff would have to call someone in and wait until they got here" or "roll the resident's bed out of their room or roll the client out of bed and roll them out the door". CNS-D did not know if either R2 or R3's doors were wide enough to get their bed through. A document titled Care Partners Homecare LLC Weekly Scheduled [sic] dated December 12, 2022, through February 26, 2023, indicated the licensee consistently scheduled one staff on the night shift, 11:00 p.m. to 7:00 a.m.. The Staffing and Scheduling policy dated August 1, 2021, indicated the clinical nurse supervisor will develop and implement a written staffing plan that provides an adequate number of qualified direct care staff to meet the residents needs 24 hours a day, seven days a week. The Mechanical Lifts Competency document (undated) indicated all mechanical lifts required two staff to safely operate. The Uniform Disclosure of Assisted Living Services and Amenities (UDALSA) document dated May 5, 2021, indicated mechanical lift: assist of two transfers as an available service at the facility. TIME PERIOD FOR CORRECTION: Two (2) days.	0 470		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the	0 480		

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0 480	Continued From page 6 following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the licensee failed to make food available at all times to three of three residents (R1, R2, and R3) reviewed. The facility placed canned and boxed food in upper cupboards (which was inaccessible to the residents in wheelchairs), lacked food in the refrigerator, disallowed R1 access to the refrigerator, and placed food in locked freezers out in the garage. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). Findings include: R1 admitted to the facility on November 23, 2021, due to diagnoses that included history of psychosis, cauda equina syndrome, and osteoarthritis. R1 lived in a room on the upper level of the facility. R1's individual abuse prevention plan (IAPP) dated November 15, 2022, indicated R1 required a wheelchair and did not ambulate. R1's document titled Habilitation Documentation Record for February 2023, indicated services	0 480	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living 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	

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0 480	Continued From page 7 provided included "Offer client breakfast based on menu", "Offer client launch [sic] based on house menu", "Offer client supper based on house menu", and "Offer client 2 snacks per day". R2 admitted to the facility on February 2, 2023, due to diagnoses that included chronic kidney disease, morbid obesity, schizoaffective disorder, congestive heart failure, and traumatic brain injury. R2 lived in a room on the lower level of the facility. R2's IAPP dated February 1, 2023, indicated R2 required a wheelchair and did not ambulate. R2's document titled Habilitation Documentation Record for February 2023, indicated services provided included "Offer client breakfast based on menu", "Offer client launch [sic] based on house menu", "Offer client supper based on house menu", and "Offer client 2 snacks per day". R3 admitted to the facility on July 26, 2022, due to diagnoses that included schizophrenia, heart failure, chronic obstructive pulmonary disease, chronic respiratory failure, and neurocognitive impairment. R3 lived in a room on the lower level of the facility. R3 's IAPP dated July 29, 2022, indicated R2 required a wheelchair and did not ambulate. R3's document titled Habilitation Documentation Record for February 2023, indicated services provided included "Offer client breakfast based on menu", "Offer client launch [sic] based on house menu", "Offer client supper based on house menu", and "Offer client 2 snacks per day". During an interview on February 21, 2023, at 6:45	0 480	ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	

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0 480	Continued From page 8 a.m. R1 stated the facility never had food available in the refrigerator, only had things like boxed macaroni and cheese or cream soups. R1 stated the licensee did not allow him into the kitchen. R1 recommended the investigator look in the refrigerator and cupboards. R1 stated he had to buy his own food and kept it in his room, because staff did not know how to cook. During an interview on February 21, 2023, at 7:15 a.m. R2 stated the facility fed the residents hotdogs and lots of mushroom soup. The resident stated it seemed like they had no food in the house, but he had not seen because he was confined to his bed on the lower level, so staff just brought him meals. During an interview on February 21, 2023, at 7:30 a.m. R3 stated the meals needed improvement and he was not aware that there was a menu. R3 stated the staff never sat him up to eat and he was confined to his room on the lower level. During an interview on February 21, 2023, at 7:50 a.m. clinical nurse supervisor (CNS)-D stated R1 (who was the only resident living on the same floor as the kitchen) was not allowed to open the refrigerator "because of infection control issues" and R1 had his own food in his own refrigerator in his room. CNS-D stated the menu rotated every week, but most residents did not want what was on the menu, so they rarely followed it. CNS-D acknowledged the lack of accessible food and stated, "we need to go shopping today". During an observation of the facility on February 21, 2023, at 8:30 a.m. CNS-D opened the refrigerator which contained a pitcher of an orange drink, several loaves of bread, a jar of mayonnaise, an opened bag of carrots, several	0 480		

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0 480	Continued From page 9 bottles of condiments, and a drawer with approximately two dozen eggs. The freezer (which was on top) contained frozen french toast sticks, French fries, a roll of cookie dough, and Schwann's containers belonging to R1. During an observation/tour of the garage area on February 21, 2023, at 8:32 a.m. CNS-D pointed out two freezers of stored food. The investigator observed the freezers to have padlocks on them. CNS-D stated only staff had access to the freezer food. During an observation/tour of the kitchen on February 21, 2023, at 8:35 a.m. CNS-D opened an upper cabinet to the left of the refrigerator, which contained approximately one dozen cans of cream soup (cream of mushroom and cream of chicken), two cans of green beans, approximately six cans of peach slices, 19 boxes of macaroni and cheese, an opened box of pancake mix, a bag of sugar, and a bag of croutons. CNS-D opened a second upper cabinet, which contained bags of tortilla chips, taco shells, soup crackers, and eight boxes of cereal (four of which expired December 2022). There was no fresh fruit. The facility document titled Menu 2 (identified by CNS-D as the current week's menu) posted in the common living area on the upper level indicated breakfast for Tuesday (the day of the investigation) consisted of pancakes, scrambled eggs, or cold cereal. The menu indicated for lunch on Tuesday was turkey taco salad with salsa and sour cream, or grill cheese sandwich with pickles and grapes. The menu indicated for snack 1 on Tuesday was an oatmeal or raisin cookie. The menu indicated for dinner on Tuesday was meatball in pasta and green beans or fish fillet sandwich with tartar sauce, veggie,	0 480		

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0 480	Continued From page 10 and grapes. The menu indicated for snack 2 on Tuesday was one banana or one scoop of vanilla ice cream. The Food Service and Menu planning policy dated August 1, 2021, indicated residents had the right to access food at any time, and the facility would not restrict access to food unless certain circumstances made it necessary for a resident's health, safety, and was documented in the resident record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) Days	0 480		
0 680 SS=I	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually	0 680		

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0 680	Continued From page 11 available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the licensee failed to ensure a written emergency disaster plan contained all required content, including information for evacuation of three of three residents (R1, R2, and R3). R2 and R3 required two-person mechanical lift transfers and relied on wheelchairs for mobility, and R1 required a wheelchair for mobility, in the event of an emergency. The facility did not ensure a plan was developed for emergencies that occurred when only one staff was at the facility. The facility was notified of the immediacy on February 21, 2023. The immediacy was removed on March 1, 2023, however, scope and severity remains at an I. 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). Findings include: The facility was licensed as an assisted living facility.	0 680	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living 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	

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	37378	A. BUILDING: _____ B. WING _____	C 03/01/2023

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0 680	Continued From page 12 R1 admitted to the facility on November 23, 2021, due to diagnoses that included history of psychosis, cauda equina syndrome, and osteoarthritis. R1 lived in a room on the upper level of the facility. R1's individual abuse prevention plan (IAPP) dated November 15, 2022, indicated R1 required a wheelchair and did not ambulate. R2 admitted to the facility on February 2, 2023, due to diagnoses that included chronic kidney disease, morbid obesity, schizoaffective disorder, congestive heart failure, and traumatic brain injury. R2 lived in a room on the lower level of the facility. R2's IAPP dated February 1, 2023, indicated R2 required a wheelchair and did not ambulate. R3 admitted to the facility on July 26, 2022, due to diagnoses that included schizophrenia, heart failure, chronic obstructive pulmonary disease, chronic respiratory failure, and neurocognitive impairment. R3 lived in a room on the lower level of the facility. R3 's IAPP dated July 29, 2022, indicated R2 required a wheelchair and did not ambulate.. During an observation on February 21, 2023, at 6:30 a.m. the investigator noted the facility was a split-level building with a landing inside the front door entrance, stairs to the upper level with a stair lift attached on the side, and stairs to the lower level with a stair lift attached on the side. The licensee had no exit diagrams on either the lower or upper floor.	0 680	USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	

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0 680	Continued From page 13 During an observation on February 21, 2023, from 6:30 a.m. to 7:00 a.m. The investigator observed one staff in the building for the three residents. During a tour of the facility on February 21, 2023, at 7:50 a.m. with clinical nurse supervisor (CNS)-D, the investigator observed the lower-level exit which opened onto a patio that was covered with ice and connected to a walkway up a hill to the driveway, which connected with the street. The investigator observed the walkway also covered with ice, rendering it impassable due to the angle. This was the only exit for residents living on the lower level and as there was not a street at the back of the facility, and this was the only outside walkway from the lower back to upper streetside of the property. During an interview on February 21, 2023, at 6:30 a.m. unlicensed personnel (ULP)-A stated she was the only staff on the night shift, 11:00 p.m. to 7:00 a.m., and did not get residents out of bed on the night shift. ULP-A stated if there was an emergency, she would call the nurse for help or call 911. During an interview on February 21, 2023, at 6:45 a.m. R1 stated there was only one staff who worked on the night shift, and R1 stated he often saw the night staff sleeping on the couch on the main floor. R1 stated he had concerns for the two residents [R1 and R2] on the lower level if there was an emergency at night, as one staff could never get them out. R1 stated the lower-level exit was impassable due to ice buildup that the licensee did not remove. (The investigator observed and confirmed the ice completely covered the sidewalk from the upper-level driveway down to the back exit door which	0 680		

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0 680	Continued From page 14 prevented anyone from walking on it.) R1 stated he missed appointments because the mobility company could not bring his wheelchair up the back sidewalk. R1 stated he would need a staff to carry his wheelchair to the landing, he would use the stair lift down, transfer to the wheelchair, and use the ramp from the garage to the outside. R1 stated staff could not lift his wheelchair. During an interview on February 21, 2023, at 7:15 a.m. R2 stated he feared he would burn up with the house if there was a fire, because there are not enough staff to get him out of bed, much less out of the building. During an interview on February 21, 2023, at 7:30 a.m. R3 stated staff did not get him up because he needed two staff with the mechanical lift to get out of bed and there was only one staff at night. During an interview on February 21, 2023, at 7:45 a.m., CNS-D stated the full mechanical lift the facility used for transferring R2 and R3 required two staff to operate. CNS-D stated they schedule one staff on night shift 11:00 p.m. to 7:00 a.m., and if there was an emergency "staff would have to call someone in and wait until they got here" or "roll the resident's bed out of their room or roll the client out of bed and roll them out the door". CNS-D did not know if either R2 or R3's doors were wide enough to get their bed through. CNS-D acknowledged the lower-level exit was impassable by walking or wheelchair due to the angle of the walkway and the thick covering of ice. A document titled Care Partners Homecare LLC Weekly Scheduled [sic] dated December 12, 2022, through February 26, 2023, indicated the licensee consistently scheduled one staff on the	0 680		

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0 680	Continued From page 15 night shift, 11:00 p.m. to 7:00 a.m. The Emergency Preparedness Plan (undated) indicated staff would concentrate on assisting less mobile clients or clients in immediate danger and in the case of a fire move all clients away from danger by the safest exit. The plan indicated in case of severe weather to move clients to an interior area away from windows. The plan indicated in case of flooding to evacuate clients. The plan did not provide specific directions for staff evacuation of residents who required two-person mechanical lift transfers and/or relied on wheelchairs for mobility. The Emergency Preparedness policy dated August 1, 2021, indicated the licensee emergency preparedness plan would include all required elements. TIME PERIOD FOR CORRECTION: Two (2) days.	0 680		
0 770 SS=I	144G.45 Subdivision 1 Minimum site Requirements The following are required for all assisted living facilities: (1) public utilities must be available, and working or inspected and approved water and septic systems must be in place; (2) the location must be publicly accessible to fire department services and emergency medical services; (3) the location's topography must provide sufficient natural drainage and is not subject to flooding; (4) all-weather roads and walks must be provided within the lot lines to the primary entrance and the	0 770		

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0 770	Continued From page 16 service entrance, including employees' and visitors' parking at the site; and (5) the location must include space for outdoor activities for residents. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the licensee failed to ensure the facility provided accessibility to the fire department and emergency medical services. The lower-level exit was covered in ice, as well as the only walkway up and around to the front of the building, driveway, and street. There was no street entrance from the back of the building. This had the potential to affect all residents, staff, and visitors. The facility was notified of the immediacy on February 21, 2023. The immediacy was removed on March 1, 2023, however, scope and severity remains at an I. 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). Findings include: R1 admitted to the facility on November 23, 2021, due to diagnoses that included history of psychosis, cauda equina syndrome, and osteoarthritis. R1 lived in a room on the upper level of the facility.	0 770	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living 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	

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0 770	Continued From page 17 R1's individual abuse prevention plan (IAPP) dated November 15, 2022, indicated R1 required a wheelchair and did not ambulate. R2 admitted to the facility on February 2, 2023, due to diagnoses that included chronic kidney disease, morbid obesity, schizoaffective disorder, congestive heart failure, and traumatic brain injury. R2 lived in a room on the lower level of the facility. R2's IAPP dated February 1, 2023, indicated R2 required a wheelchair and did not ambulate. R3 admitted to the facility on July 26, 2022, due to diagnoses that included schizophrenia, heart failure, chronic obstructive pulmonary disease, chronic respiratory failure, and neurocognitive impairment. R3 lived in a room on the lower level of the facility. R3 's IAPP dated July 29, 2022, indicated R2 required a wheelchair and did not ambulate. During entrance to the facility on February 21, 2023, at 630 a.m. the investigator observed the facility was a split-level building. Inside the front door entrance was a small landing, to the left was a door to the garage, which had a wheelchair accessible ramp. To the right of the front door were stairs going down to the lower level with a stair lift attached, and stairs going to the upper level with a stair lift attached. During a tour of the facility on February 21, 2023, at 7:50 a.m. with clinical nurse supervisor (CNS)-D the investigator observed the lower level. To the right of the stairs were two resident rooms. To the left of the stairs was a marked exit	0 770	ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	

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0 770	Continued From page 18 door (French door style) which opened out onto a cement patio, which was covered with ice. The patio connected on the left to a walkway up a hill to the driveway on the street (front) side of the building. The investigator observed the walkway also thickly covered with ice, complicated by a sharp upward angle, rendering it impassable. This was the only identified exit for residents living on the lower level as there was not a street at the back of the facility and, this was the only outside walkway from the lower back of the building to the upper street side of the building. During interview on February 21, 2023, at 6:30 a.m. unlicensed personnel (ULP)-A stated she was the only staff on the night shift 11:00 p.m. to 7:00 a.m. and did not get the residents out of bed on the night shift. ULP-A stated if there was an emergency, she would call the nurse for help or call 911. ULP-A had no idea how they would evacuate R2 or R3. During an interview on February 21, 2023, at 6:45 a.m. R1 stated he had concerns for the two residents [R1 and R2] on the lower level if there was an emergency at night, as the facility provided one staff, who could never get them out. R1 stated the lower-level exit was impassable due to ice buildup that the licensee did not remove. R1 stated he had missed several medical appointments because the medical transporters could not get him from the lower level up the walkway and into the transport van because of the ice. R1 stated the other option to get out of the facility would require a staff to carry his wheelchair to the landing, he would use the stair lift down, transfer to the wheelchair, and use the ramp from the garage to the outside. However, staff could not lift his wheelchair down the stairs.	0 770		

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0 770	Continued From page 19 During an interview on February 21, 2023, at 7:15 a.m. R2 stated he feared he would burn up with the house if there was a fire, because there are not enough staff to get him out of bed, much less out of the building. During an interview on February 21, 2023, at 7:45 a.m., CNS-D stated the licensee scheduled one staff on night shift 11:00 p.m. to 7:00 a.m., and if there was an emergency "staff would have to call someone in and wait until they got here" or "roll the resident's bed out of their room or roll the client out of bed and roll them out the door". CNS-D acknowledged the lower-level exit was impassable by walking or wheelchair due to the angle of the walkway and the thick covering of ice. TIME PERIOD FOR CORRECTION: Two (2) days.	0 770		