DEPARTMENT OF HEALTH

STATE LICENSING COMPLIANCE REPORT

Report #: HL377117686C

Date Concluded: October 14, 2024

Name, Address, and County of Facility Investigated:
Comfort Care Center LLC
3236 Brunswick Avenue South
St. Louis Park, MN 55416
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Erin Johnson-Crosby, 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
	37711	A. BUILDING: _____ B. WING _____	C 09/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMFORT CARE CENTER LLC	3236 BRUNSWICK AVENUE SOUTH EDINA, MN 55416

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER 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: #HL377117686C On September 24, 2024, 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 two residents receiving services under the provider's Assisted Living license. The following correction orders are issued for #HL377117686C, tag identification 0470, 0485, 0730, 0780, 0800, 1620, 1640, 1650.	0 000		
0 470 SS=F	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;	0 470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37711	A. BUILDING: _____ B. WING _____	C 09/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMFORT CARE CENTER LLC	3236 BRUNSWICK AVENUE SOUTH EDINA, MN 55416

(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 1 (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 interview, and record review, the licensee failed to ensure they always had sufficient staffing 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. In addition, the licensee failed to develop and implement a staffing plan and evaluation for determining appropriate staffing levels to meet the needs of 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	0 470	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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37711	A. BUILDING: _____ B. WING _____	C 09/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMFORT CARE CENTER LLC	3236 BRUNSWICK AVENUE SOUTH EDINA, MN 55416

(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 2 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: The licensee's Uniform Disclosure of Assisted Living Services and Amenities, dated October 30, 2021, indicated unlicensed staff were in the building and available to respond to resident requests 24/7 and there was one day shift staff and one night shift staff. During the entrance conference on September 24, 2024, at 11:00 a.m., licensed assisted living director (LALD)-A stated unlicensed staff must be at the facility 24/7 and must be always awake. During the facility tour on September 24, 2024, at 11:30 a.m., the investigator observed two bedrooms in the basement and one bedroom was occupied by a resident. The other bedroom had a bed with bedding, but no resident occupied that room. R1's progress notes dated July 24, 2024, written by registered nurse (RN)-B indicated RN-B arrived at the facility and there were no staff available to assist but staff were coming in later. Complaint documents indicated on August 21, 2024, indicated during a visit there were no staff present during a visit that lasted approximately 30 to 45 minutes. When they left, facility staff were walking a few blocks away from the facility. The document also indicated concerns with staff availability 24/7 and awake staff.	0 470	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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37711	A. BUILDING: _____ B. WING _____	C 09/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMFORT CARE CENTER LLC	3236 BRUNSWICK AVENUE SOUTH EDINA, MN 55416

(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 3 On September 24, 2024, at 11:50 a.m., R1 stated there were times when no staff were available at the facility and there had been multiple times at night where he had to wake up the staff sleeping in the open bedroom downstairs. Text messages dated October 2, 2024, indicated on September 30, 2024, at 3:30 a.m., a continuous loud tone was going off and noticed the carbon monoxide detector was red. R1 woke up the other resident and the staff and called the fire department. Multiple attempts were made to interview RN-B regarding the progress note written and how long staff were not at the facility. RN-B did not respond to repeated interview requests. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		
0 485 SS=F	144G.41 Subdivision 1. (13)(i)(A)and(C) Minimum Requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (A) menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of	0 485		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37711	A. BUILDING: _____ B. WING _____	C 09/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMFORT CARE CENTER LLC	3236 BRUNSWICK AVENUE SOUTH EDINA, MN 55416

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 485	Continued From page 4 similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes; and (C) the facility cannot require a resident to include and pay for meals in their contract; (ii) weekly housekeeping; (iii) weekly laundry service; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure at least three nutritious meals were served daily according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On September 24, 2024, at 11:00 a.m., the surveyor observed the daily menu hung on the wall covered in brown spots which appeared to be caused by flies. The daily menu was the same for each day of the week and included the following: -Breakfast menu: omelet with bread, cereal with milk, boiled eggs with bread, nutritious bar, or client's choice. -Lunch menu: chicken sandwich, cheeseburger, taco supreme, pizza, grill cheese, tuna sandwich	0 485		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37711	A. BUILDING: _____ B. WING _____	C 09/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMFORT CARE CENTER LLC	3236 BRUNSWICK AVENUE SOUTH EDINA, MN 55416

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 485	Continued From page 5 or client's choice. -Dinner menu: rice with chicken, pasta with ground beef, spaghetti with meatball, or client's choice. Snacks included fresh apple, orange, chips, banana, or nutrition bar. The menus lacked at least three nutritious meals daily according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines. On September 24, 2024, at 11:50 a.m., R1 stated at times the licensee runs out of food and R1 had to purchase food himself. On September 27, 2024, at 11:00 a.m., licensed assisted living director (LALD)-A stated he was not aware of the menu requirements or the USDA guidelines. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 485		
0 730 SS=F	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history,	0 730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37711	A. BUILDING: _____ B. WING _____	C 09/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMFORT CARE CENTER LLC	3236 BRUNSWICK AVENUE SOUTH EDINA, MN 55416

(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
0 730	Continued From page 6 allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the resident record included documentation of all services	0 730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37711	A. BUILDING: _____ B. WING _____	C 09/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMFORT CARE CENTER LLC	3236 BRUNSWICK AVENUE SOUTH EDINA, MN 55416

(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
0 730	Continued From page 7 provided for one of one resident (R1) reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: R1 was admitted on September 7, 2022, with diagnoses included mental health disorders, depression, and a torn rotator cuff. R1's service plan/care plan dated September 7, 2022, indicated R1 required assistance with dressing as needed, meal preparation, putting cream on legs/massaging, toileting as needed, transfers and mobility as needed, laundry twice weekly, housekeeping daily, vital signs daily if he allows, and hoarding management daily. The description of services did not include how staff should assist R1 with services. R1's last comprehensive assessment dated September 7, 2022, indicated R1 has had unsuccessful placements due to hoarding. The assessment indicated a Brief Interview for Mental Status (BIMS) with a score of 14, indicating R1 was cognitively intact; however, moderately impaired was circled on the assessment. The ssessment also indicated R1 was resistive to cares, verbal and physical aggression, hostility, defiance, and angry outbursts, but did not include interventions to attempt to prevent the behavioral symptoms. The assessment indicated R1 self-administered all medications. The last note	0 730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37711	A. BUILDING: _____ B. WING _____	C 09/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMFORT CARE CENTER LLC	3236 BRUNSWICK AVENUE SOUTH EDINA, MN 55416

(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
0 730	Continued From page 8 written by the RN indicated R1 was highly agitated and has not been willing to follow through with cleaning up. The note did not include interventions staff are supposed to assist R1 with hoarding or cleaning. R1's daily chart was typed on the computer and included staff initials. The chart did not include a description of services required. The licensee did not provide September's documentation of services for R1. On September 24, 2024, at 12:40 p.m., unlicensed personnel (ULP)-C stated there was not a document with information of what services each resident required. ULP-C also stated there was not a document for staff to sign off on if the services were provided or refused by the resident. On September 25, 2024, at 2:47 p.m., registered nurse (RN)-B stated she was not aware of the requirements regarding documentation of services and stated the LALD was responsible for the service plan. On September 27, 2024, at 11:00 a.m., licensed assisted living director (LALD)-A stated the unlicensed staff do not document services provided but he documents the staff initials. LALD-A stated he did not have a working printer, so he had to chart the services the unlicensed staff provided. A policy was requested but not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37711	A. BUILDING: _____ B. WING _____	C 09/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMFORT CARE CENTER LLC	3236 BRUNSWICK AVENUE SOUTH EDINA, MN 55416

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 780 SS=I	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (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, interview and record review, the licensee failed to comply with the State Fire Code in Minnesota Rules, chapter 7511 regarding working carbon monoxide detectors. This had the potential to affect two out of two residents (R1, R2), staff and visitors. This practice resulted in a level three violation (a violation that harmed a resident's health or safety,	0 780		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37711	A. BUILDING: _____ B. WING _____	C 09/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMFORT CARE CENTER LLC	3236 BRUNSWICK AVENUE SOUTH EDINA, MN 55416

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 780	Continued From page 10 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: The licensee's Uniform Disclosure of Assisted Living Services and Amenities, dated October 30, 2021, indicated the facility had a non-emergency and emergency On September 24, 2024, at 10:30 a.m., the investigator entered the facility for a complaint investigation and noted a beeping sound that appeared to be a dead battery in a fire alarm or carbon monoxide detector. More than one hour later, the investigator requested the licensed assisted living director (LALD)-A fix the carbon monoxide detector that continued to beep. On September 24, 2024, at 1:00 p.m., LALD-A stated he would need someone to come and fix the carbon monoxide detector since he did not have the correct battery. At that time, the carbon monoxide detector continued to beep. On September 24, 2024, at 12:00 p.m., R1 stated the carbon monoxide detecter alarm had been going off and beeping for two days. A picture reviewed by the MDH investigator indicated the carbon monoxide detector was manufactured April 2014. Text messages dated October 2, 2024, indicated a continuous loud tone was going off and it was	0 780		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37711	A. BUILDING: _____ B. WING _____	C 09/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMFORT CARE CENTER LLC	3236 BRUNSWICK AVENUE SOUTH EDINA, MN 55416

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 780	Continued From page 11 noticed the carbon monoxide detector was red. R1 woke up another resident and the staff and called the fire department. The fire department ripped the carbon monoxide detector off the wall and noticed the detector was expired. At that time, the detector was not replaced. Fire Department records dated September 30, 2024, at 3:33 a.m., indicated the fire department arrived to find the carbon monoxide detector alarm sounding with a constant beep. The crew removed the carbon monoxide detector and found it to be expired. The crew monitored the house and found a normal reading and advised the homeowner to replace the detector. No further information was provided. Time period to correct: Two (2) days	0 780		
0 800 SS=I	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 regarding the	0 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37711	A. BUILDING: _____ B. WING _____	C 09/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMFORT CARE CENTER LLC	3236 BRUNSWICK AVENUE SOUTH EDINA, MN 55416

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 800	Continued From page 12 health, safety, comfort, and well-being of the residents. This had the potential to affect all residents of the facility. 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: An MDH compliance survey dated January 20, 2023, indicated numerous physical environment concerns including, non-working light bulbs, ceiling paint bubbling in the upstairs bathroom. Upstairs were multiple plug strips daisy chained with an extension cord feeding off one of the plug strips providing power to two fish tanks and heaters. The orders also indicated the licensee's dishwasher did not work. The licensee's Quality Management Meeting minutes dated March 30, 2024, included a recent survey plan of correction orders that indicated all issues had been corrected and audits would be conducted to ensure compliance. Complaint documents dated August 22, 2024, indicated cobwebs/spiderwebs were observed in common areas, and bedrooms, and fly traps around the facility were full of small flies and regular house flies. A bucket of water with things floating in it was observed in the patio area. Food and crumbs were observed on the floor next to R1's bed. The complaint document also indicated	0 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37711	A. BUILDING: _____ B. WING _____	C 09/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMFORT CARE CENTER LLC	3236 BRUNSWICK AVENUE SOUTH EDINA, MN 55416

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 800	Continued From page 13 concerns with staff sleeping at night or not being available. On September 24, 2024, at 10:45 a.m., licensed assisted living director (LALD)-A and the MDH investigator toured the facility. During the tour, the MDH investigator observed a blank copy of the Housekeeping Services Checklist that hung on the wall of the facility was covered in brown spots, indicated the living areas and bedrooms would be vacuumed and dusted, the bathrooms and kitchen would be swept, mopped, and cleaned. LALD-A brought the investigator to the garage, upstairs, and outside to the areas where R1's items were located. R1's medical record included an incident report dated January 15, 2024, which indicated R1 was in the kitchen when he tripped and fell over a broken floor tile and hit his head on the counter which caused a massive headache. Later that day, R1 was taken to the emergency room. On September 24, 2024, at 11:36 a.m., the investigator observed and took pictures of the following: -cobwebs in every corner - the walls were covered in brown spots that appeared to be caused by flies. - the licensee's postings were also covered in brown spots -flies and gnats flying throughout the facility. - the walls were dirty with scuffs and stains and appeared to have not been cleaned. -boxes of food were sitting open on top of the refrigerator - the entry way, kitchen, and dining room floors had multiple area rugs, causing a potential trip hazard - the flooring was coming up beneath the rugs.	0 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37711	A. BUILDING: _____ B. WING _____	C 09/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMFORT CARE CENTER LLC	3236 BRUNSWICK AVENUE SOUTH EDINA, MN 55416

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 800	Continued From page 14 -the floors were unkempt and appeared to not have swept or mopped as there was dust and debris covering the floor. -mold was noted behind the sink. -next to the sink, there were clean dishes sitting in the drip tray to dry with multiple flies around the area. -the counters were dirty with various spills and food particles. - the toaster cord was frayed. - In the upper-level bathroom, it was observed that only one out of four bulbs worked . -the ceiling paint was bubbled. -In the upper-level common space, multiple plug strips were daisy-chained with an extension cord feeding off one of the plug strips to provide power to two fish tanks. The plug strips were all attached by a multi-tap plug device; these elements creating a potential fire hazard. -the patio area contained multiple birds; some in cages and two of their cages were covered in bird feces. There were also two cats in the other area of the facility. -the patio sliding door had a slight gap in the opening to the rest of the house. R1's bedroom was filled with items and appeared to have never been vacuumed. There were food items on R1's floor. During the entirety of the onsite visit on September 24, 2024, there was a beeping that went off approximately every 30 seconds coming from the carbon monoxide detector upstairs. LALD-A stated he would have to get someone to come and fix it since it was wired. Staff working confirmed the beeping had been going on for four days. On September 24, 2024, at 12:40 a.m., unlicensed personnel (ULP)-C stated there was	0 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37711	A. BUILDING: _____ B. WING _____	C 09/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMFORT CARE CENTER LLC	3236 BRUNSWICK AVENUE SOUTH EDINA, MN 55416

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 800	Continued From page 15 not a cleaning schedule and was not aware of the cobwebs and had never washed the walls. ULP-C verified she had never vacuumed R1's room as there was not enough space to do so due to all R1's items. On September 27, 2024, at 11:00 a.m., LALD-A stated staff should clean every day and the only problem was R1's items. When asked about the cleanliness about the facility LALD-A did not respond and continued to bring up R1's hoarding. LALD-A stated he would have staff start using the dishwasher to ensure dishes were clean. LALD-A stated the landlord of the house and the city have filed complaints against the facility. LALD-A did not respond when questioned about the licensee's plan of correction for the last survey and the continued same concerns. On October 2, 2024, at 11:30 a.m., outside agency staff stated she was surprised at the level of services R1 was supposed to receive and if R1 did receive those services, the facility would not be in the condition it is in. The staff stated she was" very alarmed" by the condition of the facility and concerned over the lack of cleanliness. The licensee's Housekeeping and Maintenance policy dated August 1, 2021, indicated all apartments will be cleaned weekly or as requested. The policy did not include housekeeping or maintenance for the facility. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7)	0 800		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37711	A. BUILDING: _____ B. WING _____	C 09/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMFORT CARE CENTER LLC	3236 BRUNSWICK AVENUE SOUTH EDINA, MN 55416

(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
01620	Continued From page 16 (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) conducted ongoing resident monitoring and reassessment not to exceed 90 calendar days from the last date of assessment for one of one resident (R1). In addition, the RN or licensed assisted living director (LALD) were not aware of the requirements regarding assessments. 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	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37711	A. BUILDING: _____ B. WING _____	C 09/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMFORT CARE CENTER LLC	3236 BRUNSWICK AVENUE SOUTH EDINA, MN 55416

(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
01620	Continued From page 17 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: Minnesota Rules 4659.0140 Subdivision 2, regarding nursing assessments, indicates a nursing assessment or reassessment must address the Uniform Assessment Tool parts A through N and be in writing. R1 was admitted on September 7, 2022, R1's diagnoses included mental health disorders, depression, and a torn rotator cuff. R1's medical record included a Comprehensive Assessment dated September 7, 2022, and a 14-day assessment dated and signed on September 21, 2022. The 14-day assessment was not complete and only indicated "no changes". R1's medical record included notes dated December 20, 2022, March 20, 2023, June 20, 2023, September 20, 2023, December 21, 2023, March 18, 2024, June 20, 2024, and September 20, 2024. These notes were not comprehensive assessments and did not include the Uniform assessment tool's part A through N. The last comprehensive assessment for R1 was completed on September 7, 2022. On September 25, 2024, at 2:47 p.m., registered nurse (RN)-B stated she completed R1's 90-day assessments and thought it was sufficient to make a note regarding the 90-day assessment. RN-B stated a comprehensive assessment had	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37711	A. BUILDING: _____ B. WING _____	C 09/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMFORT CARE CENTER LLC	3236 BRUNSWICK AVENUE SOUTH EDINA, MN 55416

(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
01620	Continued From page 18 not been completed since admission. RN-B stated she had not worked at assisted living facilities prior to this and was not aware of the assisted living rules and regulations. On September 27, 2024, at 11:30 a.m., licensed assisted living director (LALD)-A indicated RN-B was the nurse responsible for completion of assessments. The licensee's expectations were for the nurse to complete an initial assessment upon admission, within 14 days of the initial assessment, with any change of condition and no longer than 90 days from the previous assessment. LALD-A stated he was not aware of how often comprehensive assessments were required and stated the licensee used forms from a provider organization and was not aware of any updates. A policy was requested but not provided. No further information 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 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	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37711	A. BUILDING: _____ B. WING _____	C 09/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMFORT CARE CENTER LLC	3236 BRUNSWICK AVENUE SOUTH EDINA, MN 55416

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01640	Continued From page 19 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 service plan was implemented for one of one resident (R1) with records reviewed. The licensee failed to provide identified services to R1 including assistance activities of daily living (ADL's), meals, and behavior management. 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: R1 was admitted on September 7, 2022, R1's diagnoses included mental health disorders, depression, and a torn rotator cuff. R1's service plan/care plan dated September 7, 2022, indicated R1 required assistance with	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37711	A. BUILDING: _____ B. WING _____	C 09/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMFORT CARE CENTER LLC	3236 BRUNSWICK AVENUE SOUTH EDINA, MN 55416

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01640	Continued From page 20 dressing as needed, meal preparation, putting cream on legs/massaging, toileting as needed, transfers and mobility as needed, laundry twice weekly, housekeeping daily, vital signs daily if he allows, and hoarding management daily. R1's last comprehensive assessment dated September 7, 2022, indicated R1 has had unsuccessful placements due to hoarding. The assessment indicated a Brief Interview for Mental Status (BIMS) with a score of 14, which indicated R1 was cognitively intact; however, moderately impaired was circled on the assessment. The assessment also indicated R1 was resistive to cares, verbal and physical aggression, hostility, defiance, and angry outburst, but did not include interventions to attempt to prevent the behavioral symptoms. The assessment indicated R1 self-administered all medications. The last note written by the Registered Nurse (RN) indicated R1 was highly agitated and had not been willing to follow through with cleaning up. The note did not include interventions staff are supposed to assist R1 with hoarding or cleaning. Complaint documents dated August 22, 2024, indicated concerns the licensee was not providing the services required to R1 per the customized living tool. R1's Customized Living Rates Worksheet dated September 16, 2024, indicated the licensee would provide the following services: - One hour per day of housekeeping including dusting, vacuuming, washing clothes, bird waste, cleaning tub, shower, moving furniture, cleaning walls and baseboards. - Two hours per week of shopping. - One hour per week making appointments - Four hours per week arranging non-medical	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37711	A. BUILDING: _____ B. WING _____	C 09/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMFORT CARE CENTER LLC	3236 BRUNSWICK AVENUE SOUTH EDINA, MN 55416

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01640	Continued From page 21 transportation. - One hour per day for socialization. - Three meals per day - Two snacks per day - 15 minutes per day for dressing - 20 minutes per day for grooming - 20 minutes per day reminders for medications - 30 minutes per day for vital signs - Two hours per day for short term memory problems. - Four hours per day to manage anxiety. - Two hours per day to manage repetitive behaviors. - Three hours per day to manage agitation. - Three hours per day to manage aggression. - Two hours per day to meet other cognitive and mental health needs including hoarding and self-injurious behavior. The customized living tool indicated 16 hours per day for behavioral management including assistance with hoarding. A letter dated September 17, 2024, indicated the licensee would receive a rate increase for R1 and would receive $606.51 per day totaling $111,597.84 per year. R1's medical record included no evidence of services provided to R1. R1's record included no documentation directing staff on what services to provide each shift, how to provide the service, who was to provide the service. R1's daily chart was typed in on the computer and included staff initials. There was no printed out document of services available. The chart did not include a description of services required. The licensee did not provide September's documentation of services for R1.	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37711	A. BUILDING: _____ B. WING _____	C 09/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMFORT CARE CENTER LLC	3236 BRUNSWICK AVENUE SOUTH EDINA, MN 55416

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01640	Continued From page 22 On September 24, 2024, at 12:40 p.m., unlicensed personnel (ULP)-C stated there was not a document with information of what services each resident required. ULP-C also stated there was not a document for staff to sign off on if the services were provided or refused by the resident. . On September 24, 2024, at 11:00 a.m., licensed assisted living direction (LALD)-A confirmed there was no document describing services required or provided for R1. LALD-A stated R1 refused services but confirmed these refusals were not documented. LALD-A verified the service plan should include a description of services required and specific interventions for behavior management, so staff were aware of how to provide services for each resident. On September 25, 2024, at 2:47 p.m., registered nurse (RN)-B stated she was not aware of what services R1 required but staff were supposed to help R1 with hoarding. RN-B stated she had never had a problem with R1 and R1 was always polite. RN-B stated R1 would request help but saff would not help him. RN-B stated R1 was supposed to have lotion applied to his legs, but staff refused due to religious beliefs. RN-B stated there was no document that describe what services were required and nowhere for staff to document services provided. RN-B stated she was not aware of the requirements regarding documentation of services and stated the LALD was responsible for the service plan. On October 2, 2024, at 11:30 a.m., outside agency staff stated she was surprised at the level of services R1 received and if R1 did receive	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37711	A. BUILDING: _____ B. WING _____	C 09/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMFORT CARE CENTER LLC	3236 BRUNSWICK AVENUE SOUTH EDINA, MN 55416

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01640	Continued From page 23 those services the facility would not be in the condition it is in. The staff stated she was" very alarmed" by the condition of the facility and concerned over the lack of cleanliness. The licensee's Service Plan policy dated August 1, 2021, indicated the service plan would be based on the outcome of the initial and subsequent assessments, reassessment, monitoring, and individual reviews of the resident's needs and preferences. The policy indicated the licensee will implement all services indicated in the service plan. No further information provided. TIME PERIOD TO CORRECT: Seven (7) Days	01640		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37711	A. BUILDING: _____ B. WING _____	C 09/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMFORT CARE CENTER LLC	3236 BRUNSWICK AVENUE SOUTH EDINA, MN 55416

(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
01650	Continued From page 24 emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview, and record review the licensee failed to ensure the service plan contained the required content including a description of the services to be provided, and the frequency of each service (according to the resident's current assessment and preferences), and a contingency plan for one of one resident (R1) reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: R1 was admitted on September 7, 2022, R1's diagnoses included mental health disorders, depression, and a torn rotator cuff. R1's service plan/care plan dated September 7, 2022, indicated R1 required assistance with	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37711	A. BUILDING: _____ B. WING _____	C 09/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMFORT CARE CENTER LLC	3236 BRUNSWICK AVENUE SOUTH EDINA, MN 55416

(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
01650	Continued From page 25 dressing as needed, meal preparation, putting cream on legs/massaging, toileting as needed, transfers and mobility as needed, laundry twice weekly, housekeeping daily, vital signs daily if he allows, and hoarding management daily. The service plan did not include a description of R1 services, frequency of services provided according to the resident's current assessment and preferences. The service plan also did not include a contingency plan. R1's last comprehensive assessment dated September 7, 2022, indicated R1 has had unsuccessful placements due to hoarding. The assessment indicated a Brief Interview for Mental Status (BIMS) with a score of 14, indicated R1 was cognitively intact, however moderately impaired was circled on the assessment. The assessment also indicated R1 was resistive to cares, verbal and physical aggression, hostility, defiance and angry outburst, but did not include interventions to attempt to prevent the behavioral symptoms. The assessment indicated R1 self-administered all medications. On September 25, 2024, at 2:47 p.m., registered nurse (RN)-B stated she was not aware of the requirements for service plans and stated the licensed assisted living director (LALD)- A was responsible for the service plan. RN-B was not aware that information from the assessments indicated what services each resident required. On September 27, 2024, at 11:00 a.m., LALD-A stated the service plan form was from a provider organization and he was not aware of any updates to the form. LALD-A verified the service plan should include a description of services required and specific interventions for behavior management, so staff were aware of how to	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37711	A. BUILDING: _____ B. WING _____	C 09/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMFORT CARE CENTER LLC	3236 BRUNSWICK AVENUE SOUTH EDINA, MN 55416

(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
01650	Continued From page 26 provide services for each resident. The licensee's Service Plan policy dated August 1, 2021, indicated service plans are based on the outcomes of initial and subsequent assessments, reassessments, monitoring, and individual reviews of the resident's needs and preferences. The service plan and any revisions shall include a signature or other authentication. A service plan will include: a description of the services that are provided by the most recent assessment and resident preferences, fees for services to be provided, frequency for each services based on the most recent assessment, identification of staff who will provide services, a schedule and method for the next planned assessment for monitoring, a schedule and method for the next planned monitoring of staff providing services, and a contingency plan. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	01650		