Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL388976764M
Compliance #: HL388972657C

Date Concluded: July 24, 2023

Name, Address, and County of Licensee Investigated:
Center Light Care LLC
8201 15th Avenue South
Bloomington, MN 55425
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Carrie Euerle MSN, RN
Special Investigator

Finding: Substantiated, facility responsibility

Nature of Investigation:
The Minnesota Department of Health investigated an allegation of maltreatment, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557, and to evaluate compliance with applicable licensing standards for the provider type.

Initial Investigation Allegation(s):
The facility neglected the resident when supervision was not provided in accordance with the resident's plan of care.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The facility failed to provide supervision in accordance with the resident's plan of care. Facility staff was aware of the resident's vulnerabilities due to alcohol use and elopements and failed to implement interventions to protect the resident's health and safety.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator also contacted the resident's case worker. The investigation included review of the resident record including an individualized abuse

prevention plan, service plan, assessments, progress notes, care plan, and medication administration records. Hospital records and facility documentation including policies and procedures were also reviewed.

The resident resided in an assisted living facility. The resident's diagnoses included chronic alcohol abuse, chronic obstructive pulmonary disorder (COPD), respiratory failure, major depressive disorder, and personality disorder. The resident's service plan included assistance with activities of daily living, medications, vital sign monitoring, blood glucose monitoring, and oxygen administration. The resident's assessment indicated the resident was independent with ambulation, required continuous use of oxygen by nasal canula, had a history of drug and alcohol use, and became disoriented, agitated, and verbally and physically aggressive when intoxicated. The resident also had a history of wandering and elopements. Staff was directed to monitor the resident's whereabouts daily, provide constant checks for safety and elopement prevention, and provide 1:1 supervision for transportation and while shopping to reduce the risk of seeking drugs, alcohol, and eloping.

Review of the resident's record over a two-month period included seventeen separate incidents of the resident leaving the facility unsupervised and returning intoxicated. Staff documented that they transported the resident to a desired location, dropped him off, and left him unattended in the community. Further review of the documentation identified after the resident was dropped off, he would return independently (or staff would pick him up) intoxicated multiple hours later. Within this two-month time frame, the resident was sent to the emergency room (ER) three times for alcohol intoxication. Two of the ER visits (twelve days apart) were a result of the resident being found intoxicated and lost in the community. Staff were unaware of the resident's whereabouts until they were notified by police and/or the hospital of his status. The third ER visit was a result of staff contacting police due to the resident being intoxicated and making statements of self-harm.

Despite staff's awareness of the resident's history of elopements, alcohol use, and need for supervision, the resident was permitted to leave the facility unattended and unsupervised. Documentation identified the resident informed staff of his plan to leave the facility each day and staff ensured he was dressed appropriately, had his inhaler, a full tank of oxygen, and his cellphone. Staff transported the resident to his desired location and allowed him to leave independently and unattended in the community. There was no assessment completed of the resident's ability or inability to safely navigate the community independently. After being lost in the community and hospitalized for alcohol intoxication, no new interventions were implemented, and no further action was taken to ensure the resident's safety. Staff continued to allow the resident to leave the facility unsupervised and unattended.

During interview with the administrator and facility nurse, they acknowledged awareness of the resident's history of elopements, alcohol use, and his assessed need for supervision. The administrator and facility nurse were not concerned with the multiple incidents of staff dropping the resident off in the community, as the resident never snuck out of the facility, and

always told staff when he planned to leave, his desired location, and (usually) when he planned to return. The administrator and facility nurse acknowledged there were discrepancies in the actions of staff and the assessments of the resident's need for supervision and plan of care, however, stated they could not hold the resident against his will. The administrator and facility nurse felt staff "did the best they could" and made sure staff checked if he was dressed appropriately, had his oxygen, inhaler, and cellphone available to contact staff in case he got lost or needed a ride to return to the facility.

When interviewed, the resident's case manager stated she was unaware the facility allowed the resident to leave the facility unsupervised for several hours at a time. The case manager indicated the facility provided assessments with reasoning and documentation of their determination of the amount of supervision the resident required, but stated the facility was "clearly not" providing these services. The case manager stated it was "absolutely not appropriate" for facility staff to transport and leave the resident unattended in the community and felt the facility's actions enabled the resident to drink and elope from the facility.

In conclusion, the Minnesota Department of Health determined neglect was substantiated.

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.
"Substantiated" means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
Neglect means neglect by a caregiver or self-neglect.
(a) "Caregiver neglect" means the failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:
(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and
(2) which is not the result of an accident or therapeutic conduct.

Vulnerable Adult interviewed: Yes
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
None

Action taken by the Minnesota Department of Health:
The responsible party will be notified of their right to appeal the maltreatment finding.

The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit:

https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

You may also call 651-201-4200 to receive a copy via mail or email

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Hennepin County Attorney
Bloomington City Attorney
Bloomington Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38897	A. BUILDING: _____ B. WING _____	06/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTER LIGHT CARE LLC	8201 15TH AVENUE SOUTH BLOOMINGTON, MN 55425

(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 LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: #SL38897015 On June 6, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey and investigation, there were four residents receiving services under the provider's Provisional Assisted Living Facility license. INITIAL COMMENTS: #HL388972657C/#HL388976764M On June 7, 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 4 residents receiving services under the provider's Provisional Assisted Living Facility license.	0 000		

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0 000	Continued From page 1 The following correction orders are issued for #HL388972657C/#HL388976764M, tag identification 0620, 0630, 1620, 1650, 1730, 2320, 2360, 3000.	0 000		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to comply with Minnesota Food Code, Chapter 4626. This had the potential to affect all four residents residing at the facility. 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: Please refer to the additional documentation included in the Food and Beverage Establishment Inspection Reports June 6, 2023. TIME PERIOD FOR CORRECTION:	0 480		

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0 480	Continued From page 2 Twenty-One (21) days	0 480		
0 490 SS=F	144G.41 Subd 1 (13) (ii)-(vii) Minimum requirements (iv) upon the request of the resident, provide direct or reasonable assistance with arranging for transportation to medical and social services appointments, shopping, and other recreation, and provide the name of or other identifying information about the persons responsible for providing this assistance; (v) upon the request of the resident, provide reasonable assistance with accessing community resources and social services available in the community, and provide the name of or other identifying information about persons responsible for providing this assistance; (vi) provide culturally sensitive programs; and (vii) have a daily program of social and recreational activities that are based upon individual and group interests, physical, mental, and psychosocial needs, and that creates opportunities for active participation in the community at large; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to have a daily program of social and recreational activities that are based upon individual and group interests, physical, mental, and psychosocial needs for four of four 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) and was issued at a	0 490		

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0 490	Continued From page 3 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: The licensee's Uniform Disclosure of Assisted Services and Amenities (UDALSA) dated June 1, 2022, indicated the licensee provided daily social and recreational services. The licensee's undated contract indicated the licensee would provide a daily program of social and recreational activities that are based on individual and group interested, physical, mental and psychosocial needs, and that creates opportunities for active participation in the community at large; these programs will be culturally sensitive. On June 6, 2023, at 12:00 p.m., the surveyor did not observe a schedule of daily activities. R1's care plan dated May 17, 2022, indicated R1 would benefit from socializing with others at the facility and engage in activities that will increase his emotional well being. On June 6, 2023, at 11:15 a.m., during the entrance conference Licensed Assisted Living Director (LALD)-A and registered nurse (RN)-B stated each resident did their own activities and there were no scheduled daily activities. On June 22, 2023, at 3:17 p.m. the LALD and RN-B indicated there were no resident activities scheduled and resident's did not participate in activities. The LALD and RN-B confirmed no activities assessments were completed to identify	0 490		

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0 490	Continued From page 4 social and recreational activities of interest to the residents. No documentation was provided to indicate a facility activities program was implemented or available or that activity assessments were completed by the facility. The licensee's Activity Programming dated August 1, 2022, indicated on a regular basis the licensee will provide a wide range of activities and social recreation for its residents. A monthly calendar will be created and available to all residents. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 490		
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by:	0 580		

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0 580	Continued From page 5 Based on interview and record review, the licensee failed to engage in and maintain documentation of quality management activity by evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determine whether changes services, staffing, or other procedures need to be made, appropriate to the size and relevant to the type of services provided by the assisted living. This had the potential to affect all residents receiving assisted living services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on June 6, 2023, at 11:20 a.m., the surveyor asked licensed assisted living director (LALD)-A for the documentation of the licensee's quality management activities. Registered nurse (RN)-B stated there was not a set schedule for quality management meetings and indicated the current topic was to make sure residents stayed hydrated since it's hot out. The licensee's quality management meeting audit forms were reviewed and did not include information/interventions on how the identified concerns including how to prevent medications errors, infection control, and pressure sore prevention were going to be addressed to attempt	0 580		

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0 580	Continued From page 6 to prevent the identified concerns. The forms did not include any mention of resident hydration. On June 22, 2023, at 3:17 p.m. the LALD and RN-B confirmed the facility had not participated in quality management evaluation. The licensee's Quality Management Project policy dated August 1, 2022, indicated the licensee would have at least one documented quality management project in place at all times and retain records of such projects for atleast two years. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 580		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year	0 810		

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0 810	Continued From page 7 thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop a fire safety and evacuation plan with the required elements; failed to provide a maintained fire safety and evacuation plan that contains employee actions to be taken in the event of a fire or similar emergency; fire protection procedures necessary for residents, and procedures necessary for resident movement, evacuation, or relocation during a fire or similar emergency with identification of unique or unusual resident needs for the movement or evacuation; failed to provide required employee training on fire safety and evacuation and failed to conduct required evacuation drills every other month. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety, but was not likely to	0 810		

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0 810	Continued From page 8 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). Findings include: An interview and record review were conducted on June 8, 2023, at approximately 10:00 a.m. with the Licensed Assisted Living Director (LALD)-A and the Registered Nurse (RN)-B on the fire safety and evacuation plan, fire safety and evacuation training for the facility, and fire safety and evacuation drills for the facility. Record review of the available documentation indicated that the fire safety and evacuation plan was not maintained. The licensee had a copy of the Emergency Preparedness Manual Resource book. But the policy was a basic policy resource book from a third-party provider and had not been edited or updated to fit the facility. During the interview, LALD-A verified that the fire safety and evacuation plan for the facility lacked these provisions. Review of the available documentation provided by LALD-A contained the following discrepancies and these deficient conditions were visually verified by LALD-A accompanying the tour: - The policy states that all residents are behind closed doors in a safe smoke compartment when the fire alarm goes off, and the facility has a shelter-in-place policy. During the tour, it was observed that the resident's bedroom door did not have fire-rated protection, and the facility did not have any smoke compartments or smoke compartment doors to contain fire and smoke.	0 810		

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0 810	Continued From page 9 - The policy states that residents should be evacuated to the safest exit or nearest set of smoke compartment doors away from fire and smoke. This facility is a residential home and does not contain any sort of smoke compartments or smoke compartment doors to contain fire and smoke. - The policy states that when the fire alarm is triggered, all fire doors on magnetic holders will automatically close to contain smoke and fire and that residents are to remain behind these doors. The facility does not have any doors that are on magnetic door holders or that are rated for smoke and fire. The facility also does not have a fire alarm system that supports the use of magnetic door holders. - The policy states that the system was wired directly to the fire station. The facility did not have a fire alarm system that supported the direct connection to the fire station. It was observed that the posted fire safety and evacuation plan on the main level were not accurate depictions of the egress route and were not matched to the installed overhead exit signage locations. It was observed that the exit egress sign was posted over a family room window on the lower level, but the window did not have the required ladder installed outside of the window to meet to egress route requirement. During the interview, LALD-A stated that they do not use the window as an egress route and that the sign is to be removed. Record review of the available documentation	0 810		

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0 810	Continued From page 10 indicated that the fire safety and evacuation plan did not include the facility-specific procedures for resident movement evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. The facility plan did include some provisions for the relocation of residents but did not specify how to move or evacuate residents or identify the unique and unusual needs of the residents. The policy was a basic policy from a third-party provider and had not been edited or updated to fit the facility. During the interview, LALD-A stated she was not aware of any provisions in the fire safety and evacuation plan for this requirement and agreed that the fire safety and evacuation plan for the facility lacked these provisions. Record review of the available documentation indicated that the licensee did not have fire protection procedures necessary for residents included in the fire safety and evacuation plan. During interview, LALD-A verified that the fire safety and evacuation plan for the facility lacked these provisions. Record review of the available documentation indicated that employees did not receive training twice per year after initial hire. During the interview, LALD-A stated that the licensee provided annual training to employees, but not twice per year after the initial hire, on the fire safety and evacuation plan, as required by statute. During the interview, LALD-A verified this deficient condition and confirmed that there was no further documented training for the staff on the fire safety and evacuation plan as required by statute. Record review of the available documentation	0 810		

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0 810	Continued From page 11 indicated that the licensee did not conduct evacuation drills twice per year per shift and every other month as required by statute. Provided documentation indicated that the drills were conducted on 1-4-23 at 4:30 pm and 6-8-23 at 10: 00 am with no further drills being documented. LALD-A verified that there were no further documented drills for the facility and verified this deficient condition. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01290 SS=G	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure background studies were conducted prior to staff providing services, for one of one employees unlicensed personnel (ULP)-C.	01290		

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	38897	A. BUILDING: _____ B. WING _____	06/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTER LIGHT CARE LLC	8201 15TH AVENUE SOUTH BLOOMINGTON, MN 55425

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01290	Continued From page 12 This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: The licensee's staff list indicated ULP-C 's hire date was May 10, 2023. ULP-C's incomplete orientation and training forms were dated March 21, 2023. ULP-C's background study was completed on April 7, 2023. R1's March 2023 medication administration record (MAR) indicated ULP-C administered R1's medications 10 times. Seven of these times were documented prior to ULP-C's start date. R1's April 2023 MAR indicated ULP-C administered R1's medications 12 times that month. R1's April 2023 treatment administration record (TAR) indicated ULP-C completed treatments for R1 12 times that month. R1's May 2023 MAR indicated ULP-C administered medications 12 times that month. R1's progress notes dated Sunday, March 26, 2023, at 7:39 a.m., written by ULP-C indicated	01290		

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01290	Continued From page 13 ULP-C called the on-call nurse and the nurse came in to assess R1. On Saturday April 15, 2023, ULP-C noted the on-call nurse supervisor was notified R1 was drunk. On June 6, 2023, at 12:04 p.m., ULP-C administered R1's medications. ULP-C stated when there is not a nurse available she administers the insulin. On June 6, 2023, at 2:00 p.m., licensed assisted living director (LALD)-A stated ULP-C started in March and confirmed training and competencies for ULP-C were not complete. LALD-A stated ULP-C could not work alone and one of the registered nurses should always be onsite if ULP-C was working. LALD-C confirmed ULP-C did not have a supervisory visit completed or completed competencies. The licensee's Background Studies policy dated August 1, 2022, indicated no employee may provide direct services and have independent direct contact with residents until acceptable result of the background study have been received. If hired prior to receiving the results of the background study or more time is required, new hires shall not be permitted to interact or provide services to clients except under the direct supervision of another qualified staff person. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01290		
01370 SS=F	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn	01370		

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01370	Continued From page 14 (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices.	01370		

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01370	Continued From page 15 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a registered nurse (RN) trained and evaluated staff competencies in all required topics for one of one employee unlicensed personnel (ULP)-C with employee records reviewed. 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The employee list form completed by the licensee on June 6, 2023, indicated ULP-C was hired on May 10, 2023. On June 6, 2023, at 12:04 p.m., ULP-C administered R1's medications. ULP-C stated when there is not a nurse available, she administers the insulin. ULP-C's employee record lacked evidence that direct supervision occurred 30 days after orientation. ULP-C's record also indicated competency testing was not completed. ULP-C's incomplete orientation and training forms were dated March 21, 2023. ULP-C's background study was completed on April 7, 2023.	01370		

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01370	Continued From page 16 ULP-C's employee training records lacked evidence she successfully completed practical skills evaluations as required for training in accordance with assisted living 144G statutes in the following areas: -documentation requirements for all services provided; -reports of changes in the resident's condition to the supervisor designated by the facility; -basic infection control; -maintenance of a clean and safe environment; -appropriate and safe techniques in personal hygiene and grooming; -standby assistance techniques and how to perform them; -medication, exercise, and treatment reminders; -basic nutrition, meal preparation, food safety, and assistance with eating; -preparation of modified diets as ordered by a licensed health professional; -communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; -awareness of confidentiality and privacy; -understanding of appropriate boundaries between staff and residents and the resident's family; -procedures to use in handling various emergency situations; and -awareness of commonly used health technology equipment and assistive devices. On June 6, 2023, at 2:00 p.m., licensed assisted living director (LALD)-A stated ULP-C started in March and confirmed training and competencies for ULP-C were not complete. The licensee's Competency Training Evaluation	01370		

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01370	Continued From page 17 policy dated August 1, 2022, indicated prior to delegation of services the registered nurse or licensed health professional must make certain the ULP is trained in proper methods to perform the tasks and procedures for each client and are able to demonstrate the ability to competency follow the procedures and perform the tasks. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	01370		
01380 SS=F	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure training and competency evaluations were completed as	01380		

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01380	Continued From page 18 required prior to providing direct care for one of one unlicensed personnel (ULP-C) with records reviewed. 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 the potential to affect a large portion or all of the residents). The findings include: The licensee's staff list provided June 6, 2023, indicated ULP-C's hire date was May 10, 2023. On June 6, 2023, at 12:04 p.m., ULP-C administered R1's medications. ULP-C stated when there is not a nurse available she administers the insulin. ULP-C's incomplete orientation and training forms were dated March 21, 2023. ULP-C's background study was completed on April 7, 2023. ULP-C's record lacked evidence of the following education and/or competencies had been completed prior to providing direct cares: - observing, reporting, and documenting resident status; - basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel;	01380		

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01380	Continued From page 19 - reading and recording temperature, pulse, and respiration of the resident; - recognizing physical, emotional, cognitive, and developmental needs of the client; - administering medications or treatments as required. On June 6, 2023, at 2:00 p.m., licensed assisted living director (LALD)-A stated ULP-C started in March and confirmed training and competencies for ULP-C were not complete. The licensee's Competency Training Evaluation policy dated August 1, 2022, indicated prior to delegation of services the registered nurse or licensed health professional must make certain the ULP is trained in proper methods to perform the tasks and procedures for each client and are able to demonstrate the ability to competency follow the procedures and perform the tasks. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	01380		
01440 SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment	01440		

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01440	Continued From page 20 administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted direct supervision of staff performing delegated nursing task within 30 days of first providing services for one of one unlicensed personnel (ULP-C) with records reviewed. 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The employee list form completed by the licensee on June 6, 2023, indicated ULP-C was hired on May 10, 2023.	01440		

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01440	Continued From page 21 ULP-C's employee record indicated competency testing was not completed. ULP-C's employee record lacked evidence that direct supervision occurred 30 days after orientation. ULP-C's incomplete orientation and training forms were dated March 21, 2023. ULP-C's background study was completed on April 7, 2023. R1's record identified ULP-C completed direct cares, treatments and medication administration for March, April, and May of 2023. On June 6, 2023, at 2:00 p.m., licensed assisted living director (LALD)-A stated she was not aware of what a supervisory visit was and stated the supervisory visits had not been completed on any employees. The licensee's undated Supervision of Unlicensed Personnel policy, indicated the direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs delegated tasks for residents, and thereafter as needed based on performance. No further information was provided. TIME PERIOD TO CORRECT: Seven (7) days	01440		
01530 SS=D	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements:	01530		

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01530	Continued From page 22 (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure completion and documentation of required dementia training for one of one unlicensed personnel (ULP-C) with records reviewed . This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred	01530		

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01530	Continued From page 23 only occasionally). Findings include: The employee list form completed by the licensee on June 6, 2023, indicated ULP-C was hired on May 10, 2023. ULP-C's employee record lacked evidence that direct supervision occurred 30 days after orientation. ULP-C's record also indicated competency testing was not complete. ULP-C's background study was completed on April 7, 2023. ULP-C's Orientation and Training Tracking form dated March 21, 2023, indicated dementia training was not required at orientation. ULP-C's record lacked evidence of receiving at least eight hours total for dementia training within of a total 160 working hours as required. On June 6, 2023, at 2:00 p.m., licensed assisted living director (LALD)-A stated ULP-C started in March and confirmed training and competencies for ULP-C were not complete including dementia care training. The licensee's Dementia Training policy dated August 1, 2022, indicated direct care employees will complete eight hours of initial training within 160 hours of the employment start date. Employees may not provide direct care until the training is complete unless another employee who has completed the initial training is present to provide assistance No further information was provided.	01530		

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01530	Continued From page 24 TIME PERIOD FOR CORRECTION: Twenty-one (21) days .	01530		
01750 SS=G	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the licensee failed to ensure administration of medication was delegated appropriately by the registered nurse (RN) for one of one unlicensed personnel (ULP)-C. This had the potential to affect all residents who received medication administration. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or	01750		

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01750	Continued From page 25 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: The employee list form completed by the licensee on June 6, 2023, indicated ULP-C was hired on May 10, 2023. ULP-C's employee record indicated competency testing was not completed. ULP-C's employee record lacked evidence that direct supervision occurred 30 days after orientation. ULP-C's incomplete orientation and training forms were dated March 21, 2023. ULP-C's background study was completed on April 7, 2023. R1's record identified ULP-C completed direct cares, treatments, and medication administration for March, April, and May of 2023. On June 6, 2023, at 12:04 p.m., ULP-C administered R1's medications. ULP-C stated when there is not a nurse available she administers the insulin. On June 6, 2023, at 2:00 p.m., licensed assisted living director (LALD)-A confirmed ULP-C started in March 2023 and did not have a medication administration competency completed by the RN. The licensee's Competency Training Evaluation policy dated August 1, 2022, indicated prior to delegation of services the registered nurse or licensed health professional must make certain the ULP is trained in proper methods to perform the tasks and procedures for each client and are	01750		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38897	A. BUILDING: _____ B. WING _____	06/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTER LIGHT CARE LLC	8201 15TH AVENUE SOUTH BLOOMINGTON, MN 55425

(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
01750	Continued From page 26 able to demonstrate the ability to competency follow the procedures and perform the tasks. No further information was provided. TIME PERIOD TO CORRECT: Seven (7) days	01750		