



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

April 3, 2025

Licensee
Community Assisted Living Inc.
1205 6th Avenue West
Shakopee, MN 55379

RE: Project Number(s) SL21887015

Dear Licensee:

On February 27, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine the correction of orders from the survey completed on June 18, 2024, and the follow-up surveys completed on September 13, 2024, and December 23, 2024. This follow-up survey verified that the facility is in substantial compliance.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in the letter with your organization's Governing Body.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in blue ink, appearing to read 'Jess Schoenecker'.

Jess Schoenecker, Supervisor
State Evaluation Team
Email: jess.schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 1-866-890-9290

JMD



Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF REMOVAL OF CONDITIONAL LICENSE

Electronic Delivery

January 30, 2025

Licensee

Community Assisted Living Inc.
1205 6th Avenue West
Shakopee, MN 55379

RE: License Number 418394
Health Facility Identification Number (HFID) 21887
Project Number(s) SL21887015

Dear Licensee:

On December 23, 2024, The Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed December 23, 2024. Based on these findings, the condition(s) on the license were removed effective December 23, 2024.

State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

Furthermore, the follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the June 18, 2024 initial survey and September 13, 2024 follow-up survey.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a), state correction orders issued pursuant to the last survey completed on December 23, 2024, found not corrected at the time of the follow-up survey follow-up survey and/or subject to a penalty assessment are as follows:

0820 - Fire Protection And Physical Environment - 144g.45 Subd. 2 (g)

The details of the violations noted at the time of this follow-up survey completed on December 23, 2024 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, no immediate fines are assessed.

DOCUMENTATION OF ACTION TO COMPLY

Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the

correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's resident(s)/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS

In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by MDH within 15 calendar days of the correction order receipt date.

To submit a reconsideration request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in the letter and/or state form with your organization's Governing Body.

Sincerely,



Rick Michals, J.D.

Executive Regional Operations Manager

**Minnesota Department of Health
Health Regulation Division**

JMD

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 21887	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 12/23/2024
NAME OF PROVIDER OR SUPPLIER COMMUNITY ASSISTED LIVING INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1205 6TH AVENUE WEST SHAKOPEE, MN 55379		
(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 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: SL#21887015-2 On December 23, 2024, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on September 13, 2024. At the time of the survey, there were 4 active residents; 4 receiving services under the Assisted Living license. As a result of the revisit, the following orders were reissued and/or issued.	{0 000}	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
{0 480} SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	{0 480}			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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{0 480}	Continued From page 1 (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are	{0 480}			

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{0 480}	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by:	{0 480}	Not reviewed during this survey.		
{0 680} SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually	{0 680}			

Minnesota Department of Health

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{0 680}	Continued From page 3 available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by:	{0 680}	Not reviewed during this survey.		
{0 690} SS=C	144G.43 Subdivision 1 Resident record (a) Assisted living facilities must maintain records for each resident for whom it is providing services. Entries in the resident records must be current, legible, permanently recorded, dated, and authenticated with the name and title of the person making the entry. This MN Requirement is not met as evidenced by:	{0 690}			
{0 790} SS=F	144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and	{0 790}			

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{0 790}	Continued From page 4 This MN Requirement is not met as evidenced by:	{0 790}	Not reviewed during this survey.		
{0 800} SS=E	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:	{0 800}			
{0 810} SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive	{0 810}			

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{0 810}	Continued From page 5 training on the fire safety and evacuation plans upon hiring and at least twice per year 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 staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by:	{0 810}	Not reviewed during this survey.		
{0 820} SS=D	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction.	{0 820}			

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{0 820}	Continued From page 6 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure physical facility elements did not constitute a distinct hazard to life. The licensee failed to provide resident bedrooms with the minimum window opening meeting the minimum state standard for egress. This had the potential to affect some residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On December 23, 2024, surveyor conducted a revisit to follow-up on orders issued pursuant to a survey completed on September 13, 2024. On December 23, 2024, at 9:10 a.m., per phone conversation, house manager (HM)-F stated bedroom 1, 2, 3, and 4 windows were replaced but bedroom 3 needed new track hardware as it was damaged by the contractor during installation. On December 23, 2024, at 10:40 a.m., surveyor toured the facility with licensed practical nurse (LPN)-B. During the tour, survey staff asked LPN-B to open the windows in the resident bedrooms for measurement. The new windows for bedrooms 1, 2, and 4 were compliant. The	{0 820}			

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{0 820}	Continued From page 7 new window for unoccupied bedroom 3 was unable to be measured as the window fell out of the damaged track when attempted to open. The window in bedroom 3 did not meet the minimum requirements for clear width, clear height, and total openable area. On December 23, 2024, at 11:15 a.m., LPN-B stated the contractor damaged the window track when bedroom 3's window was installed. LPN-B also stated new track hardware was obtained for bedroom 3's window but was also damaged when installed the second time by the contractor. LPN-B further stated the contractor had ordered another new window for bedroom 3 and was awaiting delivery to reinstall. Surveyor explained to LPN-B and HM-F that at least one window in each bedroom in a state-licensed facility must meet the minimum state fire code standard for an egress window to be a complying bedroom for resident occupancy. LPN-B and HM-F verbally confirmed the findings. Egress windows in existing sleeping rooms must have a minimum openable width of 20 inches and minimum openable height of 20 inches with no less than 648 square inches total of openable area (4.5 square feet) for the window. No further information was provided.	{0 820}			
{01290} SS=F	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	{01290}			

Minnesota Department of Health

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{01290}	Continued From page 8 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 a staff member 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:	{01290}	Not reviewed during this survey.		
{01640} SS=D	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 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	{01640}			

Minnesota Department of Health

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{01640}	Continued From page 9 when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by:	{01640}	Not reviewed during this survey.		
{01710} SS=D	144G.71 Subd. 3 Individualized medication monitoring and reas The assisted living facility must monitor and reassess the resident's medication management services as needed under subdivision 2 when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually. This MN Requirement is not met as evidenced by:	{01710}			
{01760} SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan.	{01760}			

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{01760}	Continued From page 10	{01760}			
	This MN Requirement is not met as evidenced by:		Not reviewed during this survey.		
{01770} SS=F	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by:	{01770}			
{01790} SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if:	{01790}	Not reviewed during this survey.		

Minnesota Department of Health

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{01790}	Continued From page 11 (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication.	{01790}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 21887	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 12/23/2024
NAME OF PROVIDER OR SUPPLIER COMMUNITY ASSISTED LIVING INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1205 6TH AVENUE WEST SHAKOPEE, MN 55379		
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{01790}	Continued From page 12	{01790}			
	This MN Requirement is not met as evidenced by:		Not reviewed during this survey.		
{01880} SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by:	{01880}			
{01890} SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by:	{01890}			
{01910} SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a	{01910}			

Minnesota Department of Health

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{01910}	Continued From page 13 resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by:	{01910}	Not reviewed during this survey.		
{01940} SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration;	{01940}			

Minnesota Department of Health

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{01940}	Continued From page 14 (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by:	{01940}	Not reviewed during this survey.		
{01960} SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by:	{01960}			

Minnesota Department of Health

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{03090}	Continued From page 15	{03090}			
{03090} SS=C	144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by:	{03090}			
			Not reviewed during this survey.		



Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF CONDITIONAL LICENSE

Electronically Delivered

September 25, 2024

Licensee

Community Assisted Living, Inc.
1205 6th Avenue West
Shakopee, MN 55379

RE: Conditional License Number 413941
Health Facility Identification Number (HFID) 21887
Project Number(s) 21887

Dear Licensee:

On September 13, 2024, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on June 18, 2024. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the June 18, 2024 survey.

As a result, pursuant to Minn. Stat. § 144G.20, MDH is issuing a 90-day conditional license due to expire on **December 24, 2024**.

IMPOSITION OF FINES

In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and may be imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement.

Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;

Level 3: a fine of \$3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.

Level 4: a fine of \$5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

MDH may assess fines based on the level and scope of the orders outlined below. The total amount of **potential** fines that may be assessed related to these correction orders is \$500.00. **MDH is not imposing these fines against your license at this time.**

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on June 18, 2024, found not corrected at the time of the September 13, 2024, follow-up survey and/or subject to penalty assessment are as follows:

St - 0 - 0820 - 144g.45 Subd. 2 (g) - Fire Protection And Physical Environment - \$500.00

DOCUMENTATION OF ACTION TO COMPLY

In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders and immediately correct any reissued orders outlined on the state form; however, plans of correction are not required to be submitted for approval. **If corrections are not made, MDH may impose fines as described above and in accordance with Minnesota Statutes 144G.**

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's resident(s)/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS

In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by MDH within 15 calendar days of the correction order receipt date.

To submit a reconsideration request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

CONDITIONAL LICENSE ISSUED:

MDH will issue Community Assisted Living, Inc. a conditional assisted living facility license for 90 calendar days from the date of this notice. At an unannounced point in time, within the 90 calendar days, MDH will conduct a follow-up survey, as defined in Minn. Stat. § 144G.30, Subd. 6. Based on the results of the follow-up survey, MDH will determine if Community Assisted Living, Inc. is in substantial compliance.

The following conditions apply on the conditional assisted living facility license:

- a. **Health Facility Construction Permit: Community Assisted Living, Inc.** will contact the Minnesota Department of Labor and Industry (MNDLI) or City with delegated authority to review and inspect Sate Licensed Facilities in accordance with Minn. Stat. § 362B.103, Subd. 13, and obtain a construction permit for a health facility. **Within 14 days from the date of this notice, Community Assisted Living, Inc will provide MDH with a copy of the permit obtained from MNDLI or City with delegated authority to Tim Hanna, Supervisor, at Tim.Hanna@state.mn.us.**
- b. **Egress Window Requirements:** Community Assisted Living, Inc. will replace at least one window in bedrooms occupied by Resident 1, Resident 3 and Resident 4, meeting the minimum size requirements.
 - i. Must have minimum openable width of no less than 20 inches.
 - ii. Must have minimum openable height of no less than 20 inches.
 - iii. Must have total openable area of no less than 248 square inches (4.5 square feet).

- iv. Must have a windowsill height of no more than 48 inches from the floor to the clear opening.
- v. All measurements must be achieved under normal operation of opening window without the use of a key, tool, or special knowledge.

c. Follow-up survey: At the time of the follow-up survey, MDH may pursue additional enforcement actions, up to and including immediate temporary suspension or revocation of the provisional license if MDH identifies any level 3 or 4 violations or widespread care related violations.

RESULTS OF FOLLOW-UP EVALUATION DURING THE CONDITIONAL LICENSE PERIOD:

MDH will determine if Community Assisted Living, Inc. is in substantial compliance based on the results of the follow up survey. MDH will make this determination within the 90-day conditional license period. If MDH determines Community Assisted Living, Inc. is in substantial compliance on the follow up survey, MDH will remove the conditions from Community Assisted Living, Inc.'s assisted living facility license, and Community Assisted Living, Inc. will correct any outstanding violations identified during the survey. If Community Assisted Living, Inc. is not in substantial compliance on the follow-up survey, MDH may take additional enforcement action, up to and including immediate temporary suspension and revocation, as authorized by Minn. Stat. § 144G.20.

REQUESTING A HEARING:

Pursuant to Minn. Stat. §144G.20, Subd. 18, the licensee may appeal an action against the license under this section. The licensee must request a hearing no later than 15 business days after licensee receives notice of the action. To submit a hearing request, please visit

<https://forms.web.health.state.mn.us/form/HRD-Appeals-Form>.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in the letter and state form with your organization's Governing Body.

If you have any questions, please contact Tim Hanna directly at: 507-208-8982.

Sincerely,



Rick Michals, J.D.

Executive Regional Operations Manager

**Minnesota Department of Health
Health Regulation Division**

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 21887	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 09/13/2024
NAME OF PROVIDER OR SUPPLIER COMMUNITY ASSISTED LIVING INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1205 6TH AVENUE WEST SHAKOPEE, MN 55379		
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{0 000}	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been 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: SL21887015-1 On September 16, 2024, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on June 18, 2024. At the time of the survey, there were five residents; five receiving services under the Assisted Living license. As a result of the follow-up survey, the following orders were reissued.	{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: Not reviewed during this survey.	{0 480}			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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{0 680} SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{0 680}			
{0 690} SS=C	144G.43 Subdivision 1 Resident record (a) Assisted living facilities must maintain records for each resident for whom it is providing services. Entries in the resident records must be current, legible, permanently recorded, dated, and authenticated with the name and title of the person making the entry.	{0 690}			

Minnesota Department of Health

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{0 690}	Continued From page 2	{0 690}			
{0 790} SS=F	This MN Requirement is not met as evidenced by: Not reviewed during this survey. 144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{0 790}			
{0 800} SS=E	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	{0 800}			

Minnesota Department of Health

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{0 800}	Continued From page 3	{0 800}			
{0 810} SS=F	by: Not reviewed during this survey. 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 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.	{0 810}			

Minnesota Department of Health

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{0 810}	Continued From page 4	{0 810}			
{0 820} SS=F	This MN Requirement is not met as evidenced by: Not reviewed during this survey. 144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure physical facility elements did not constitute a distinct hazard to life. The licensee failed to provide resident bedrooms with the minimum window opening meeting the minimum state standard for egress. This had the potential to affect some residents, staff, and visitors. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected	{0 820}			

Minnesota Department of Health

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{0 820}	Continued From page 5 or has potential to affect a large portion or all of the residents). The findings include: INITIAL SURVEY: On June 17, 2024, at 11:00 a.m., survey staff toured the facility with the licensed practical nurse (LPN)-B and registered nurse (RN)-C. During the tour, survey staff asked LPN-B to open the windows in the resident bedrooms for measurement. The noncompliant measurements were as follows: In the bedroom occupied by R1 on the main level, the clear openable area of the opened windows measured 11 inches in height and 36 inches in width, with a total openable area of 396 square inches. The windows did not meet the minimum requirements for opening height and did not meet the minimum requirements for total openable area. In the bedroom occupied by R3 on the main level, the clear openable area of the opened windows measured 11 inches in height and 36 inches in width, with a total openable area of 396 square inches. The windows did not meet the minimum requirements for opening height and did not meet the minimum requirements for total openable area. In the bedroom occupied by R4 on the main level, the clear openable area of the opened windows measured 11 inches in height and 36 inches in width, with a total openable area of 396 square inches. The windows did not meet the minimum requirements for opening height and did not meet the minimum requirements for total openable	{0 820}			

Minnesota Department of Health

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{0 820}	Continued From page 6 area. Egress windows in existing sleeping rooms must have a minimum openable width of 20 inches and minimum openable height of 20 inches with no less than 648 square inches total of openable area (4.5 square feet) for the window. Survey staff explained to LPN-B and RN-C that at least one egress window in each bedroom must be provided to meet the minimum state standard for an egress window to be a complying bedroom for resident occupancy. LPN-B and RN-C verbally confirmed the findings. On June 17, 2024, at 12:00 p.m., during the interview, survey staff explained to RN-C that an immediate correction order was issued for the above finding. RN-C acknowledged the above finding. FOLLOW UP SURVEY On September 13, 2024, at 12:07 p.m., survey staff entered facility for follow up survey. Surveyor was let into the facility by unlicensed personal (ULP)-D. ULP-D stated that the licensee had not yet installed the new windows. ULP-D provided survey staff with the licensee's fire watch log. The licensee had maintained a continuous fire watch log from the initial issue of the immediate order on June 17, 2024, to the current date of the follow up survey. On September 13, 2024, at 12:10 p.m., on a phone interview license practical nurse (LPN)-B stated that the licensee had not yet replaced the windows in the facility. On September 13, 2024, at 12:24 p.m., on a phone interview, office manager (OM)-F stated	{0 820}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 21887	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 09/13/2024
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{0 820}	Continued From page 7 the licensee had been working with Home Depot to complete the install of the compliant windows. OM-F stated the licensee had difficulty in finding contractors that would be able to obtain the required building permits or were willing to install only 3 windows. OM-F stated the new windows had been purchased and were scheduled to be installed on the September 27, 2024. On September 13, 2024 at 12:38 p.m., survey staff explained to OM-F that the order would be reissued due to continue non-compliance with previous correction orders, but would be reissued at a lower level due to the licensee maintaining a continuous firewatch. OM-F acknowledged the above findings. No Further information was provided.	{0 820}			
{01290} SS=F	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.	{01290}			

Minnesota Department of Health

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{01290}	Continued From page 8 This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{01290}			
{01640} SS=D	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 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: Not reviewed during this survey.	{01640}			
{01710} SS=D	144G.71 Subd. 3 Individualized medication monitoring and reas The assisted living facility must monitor and reassess the resident's medication management	{01710}			

Minnesota Department of Health

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{01710}	Continued From page 9 services as needed under subdivision 2 when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{01710}			
{01760} SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{01760}			
{01770} SS=F	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup.	{01770}			

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{01770}	Continued From page 10	{01770}			
{01790} SS=F	This MN Requirement is not met as evidenced by: Not reviewed during this survey. 144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system;	{01790}			

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{01790}	Continued From page 11 (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{01790}			
{01880} SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access.	{01880}			

Minnesota Department of Health

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{01880}	Continued From page 12 This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{01880}			
{01890} SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{01890}			
{01910} SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given,	{01910}			

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{01910}	Continued From page 13 date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{01910}			
{01940} SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any	{01940}			

Minnesota Department of Health

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{01940}	Continued From page 14 changes. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{01940}			
{01960} SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{01960}			
{03090} SS=C	144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{03090}			

Minnesota Department of Health

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Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

July 16, 2024

Licensee
Community Assisted Living Inc
1205 6th Avenue West
Shakopee, MN 55379

RE: Project Number(s) SL21887015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on June 18, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

The enclosed State Form documents the state correction orders. MDH documents state licensing correction orders using federal software. Tag numbers are 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 are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

IMPOSITION OF FINES

In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and may be imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement.

Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;

Level 3: a fine of \$3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.

Level 4: a fine of \$5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

In accordance with Minn. Stat. § 144G.31, Subd. 4(a)(5), MDH may impose fine amounts of either \$1,000 or \$5,000 to licensees who are found to be responsible for maltreatment. MDH may impose a fine of \$1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. MDH also may impose a

fine of \$5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4(b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, the following fines are assessed pursuant to this survey:

St - 0 - 0820 - 144g.45 Subd. 2 (g) - Fire Protection And Physical Environment - \$3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$3,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's resident(s)/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS

In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by MDH within 15 calendar days of the correction order receipt date.

To submit a reconsideration request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a

hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. to submit a hearing request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **<https://forms.office.com/g/Bm5uQEPhVa>**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in the letter and state form with your organization's Governing Body.

If you have any questions, please contact me.

Sincerely,

A handwritten signature in black ink, appearing to read "Jodi Johnson", with a stylized flourish at the end.

Jodi Johnson, Supervisor

State Evaluation Team

Email: jodi.johnson@state.mn.us

Telephone: 507-344-2730 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 21887	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/18/2024
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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: SL21887015 On June 17, 2024, through June 18, 2024, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were five residents; five receiving services under the provider's Assisted Living license. 0820: An immediate correction order was identified on June 17, 2024, at a level 3/Widespread (I). The immediacy was lifted on June 18, 2024, but deficiency remains at a scope/level of I.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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0 480	Continued From page 1 (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 ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated June 17, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480			
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements:	0 680			

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER COMMUNITY ASSISTED LIVING INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1205 6TH AVENUE WEST SHAKOPEE, MN 55379		
(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
0 680	Continued From page 2 (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to have a written emergency preparedness (EP) plan with all of the required content. This had the potential to affect all residents, staff, and visitors of the assisted living 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 is issued at a widespread scope (when problems are pervasive or represent a systemic failure that	0 680			

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0 680	Continued From page 3 has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee's Emergency Preparedness plan was reviewed and lacked the following: - policy and procedure addressing the role of facility under waiver declared by the Secretary in accordance with section 1135 of the ACT; - conduct exercises to test EP at least twice per year, including unannounced staff drills using EP, including participating in an annual full-scale exercise community based or annual individual facility based functional exercise or if facility experiences an actual emergency requiring evacuation of plan, facility is exempt from engaging in its next required full scale exercise; conduct an additional annual exercise that may include a second full scale exercise community based or an individual; facility based functional exercise or mock disaster drill or table top exercise On June 18, 2024, at 10:50 a.m., registered nurse (RN)-C stated the licensee's emergency preparedness plan lacked the required content listed above. The licensee's Emergency Preparedness Plan-Appendix Z Compliance dated August 1, 2021, indicated the licensee's emergency preparedness plan would include all the required elements of Appendix Z. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680			

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0 690	Continued From page 4	0 690			
0 690 SS=C	144G.43 Subdivision 1 Resident record (a) Assisted living facilities must maintain records for each resident for whom it is providing services. Entries in the resident records must be current, legible, permanently recorded, dated, and authenticated with the name and title of the person making the entry. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure entries in the resident records were authenticated by the name and title of the person making the entry for one of one resident (R1). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: R1 was admitted on May 9, 2023, with diagnoses that included diabetes and coronary artery disease (damage or disease in the heart's major blood vessels). On June 17, 2024, at 12:14 p.m., the surveyor observed unlicensed personnel (ULP)-D administer medications to R1. R1's Home Health Aide Care Plan dated June 1, 2024, through June 30, 2024, included staff	0 690			

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0 690	Continued From page 5 initials but lacked staff names/signatures and credentials/title. R1's Monthly Bath Charting dated June 2024, included staff initials but lacked staff names/signatures and credentials/title. On June 17, 2024, at 1:12 p.m., registered nurse (RN)-C stated R1's Home Health Aide Care Plan and Monthly Bath Charting documents lacked staff names/signatures and credentials/titles. RN-C further stated these documents were used for all residents. The licensee's Resident Record- Documentation policy dated August 1, 2021, indicated all documentation would include the signature and title of the person who performed the service or administered the medication, treatment or therapy. Initials may be used if there is a completed signature page included in the documentation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 690			
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest	0 790			

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0 790	Continued From page 6 fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to perform the required monthly maintenance on fire extinguishers and failed to provide adequately rated portable fire extinguishers as required. This had the potential to affect all current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On June 17, 2024, at 11:00 a.m., survey staff toured the facility with the licensed practical nurse (LPN)-B and registered nurse (RN)-C. During the tour, it was observed that the fire extinguisher lacked records showing the required monthly visual inspections were performed on the portable fire extinguishers. It was observed the fire extinguisher by the main entrance on the main floor was 1-A:10-BC (size) rated and did not have a 2-A:10-B:C rated fire extinguisher as required.	0 790			

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0 790	Continued From page 7 On June 17, 2024, at 11:00 a.m., LPN-B verified the required maintenance had not been completed and the fire extinguisher by the main entrance did not meet the appropriate size requirement. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790			
0 800 SS=E	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 in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect residents in the rooms. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).	0 800			

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0 800	Continued From page 8 The findings include: On June 17, 2024, at 11:00 a.m., survey staff toured the facility with the licensed practical nurse (LPN)-B and registered nurse (RN)-C. During the facility tour, survey staff observed the following: In the bedroom occupied by R1 on the main level, it was observed that the window opening hardware for the egress window was removed, and LPN-B was not able to open the window. In the bedroom occupied by R4 on the main level, it was observed that the opening hardware for the window was broken and prevented the window from closing after opening. In the bathroom on the main level, it was observed that the wall-mounted toilet paper holder was broken and not securely mounted to the wall. During the tour on June 17, 2024, at 11:30 a.m., LPN-B visually verified these deficient findings at the time of discovery. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800			
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of	0 810			

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0 810	Continued From page 9 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 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 the interview and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and failed to provide the required training. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	0 810			

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0 810	Continued From page 10 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 June 17, 2024, at 1:00 p.m., licensed practical nurse (LPN)-B and registered nurse (RN)-C provided documentation on the fire safety and evacuation plan (FSEP), fire safety and evacuation training for the facility, and fire safety and evacuation drills for the facility. EMERGENCY EVACUATION PLAN The posted lower-level emergency evacuation plan was not accurate depictions of the egress route and did not match to the current layout of the resident sleeping rooms. It was observed that the bedroom door location, egress stairway layout and wall locations were not shown correctly on the lower level. It was observed the emergency exit doors were not identified in the posted evacuation plan. During the tour, it was also observed the emergency egress exits were not posted in the facility. During the interview on June 17, 2024, at 1:00 p.m., LPN-B stated the posted emergency evacuation plans needed to be updated to show the current layout of resident bedrooms and verified the plan did not show the number of resident rooms. FIRE SAFETY AND EVACUATION PLAN The FSEP and the posted evacuation plans did	0 810			

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0 810	Continued From page 11 not show the location and number of resident rooms. The FSEP included standard resident evacuation procedures but failed to provide specific procedures for resident movement and evacuation during a fire or similar emergency including individualized unique needs of residents. The plan failed to include ways to move, evacuate residents based on the facility's specific layout in the event of a fire or similar emergency. During the interview on June 17, 2024, at 1:00 p.m., LPN-B verified the facility needed to update the fire safety and evacuation plan, including the facility-specific resident evacuation procedures. TRAINING Record review of the available documentation indicated employees did not receive training twice per year after initial hire. During the interview on June 17, 2024, at 1:00 p.m., LPN-B stated the licensee provided annual training on the fire safety and evacuation plan to employees, but not twice per year after the initial hire, as required by statute. LPN-B confirmed that there was no further documented training for the staff on the fire safety and evacuation plan as required by statute. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810			
0 820 SS=I	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including	0 820			

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0 820	Continued From page 12 assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure physical facility elements did not constitute a distinct hazard to life. The licensee failed to provide resident bedrooms with the minimum window opening meeting the minimum state standard for egress. This had the potential to affect some residents, staff, and visitors. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On June 17, 2024, at 11:00 a.m., survey staff toured the facility with the licensed practical nurse (LPN)-B and registered nurse (RN)-C. During the tour, survey staff asked LPN-B to open the	0 820			

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0 820	Continued From page 13 windows in the resident bedrooms for measurement. The noncompliant measurements were as follows: In the bedroom occupied by R1 on the main level, the clear openable area of the opened windows measured 11 inches in height and 36 inches in width, with a total openable area of 396 square inches. The windows did not meet the minimum requirements for opening height and did not meet the minimum requirements for total openable area. In the bedroom occupied by R3 on the main level, the clear openable area of the opened windows measured 11 inches in height and 36 inches in width, with a total openable area of 396 square inches. The windows did not meet the minimum requirements for opening height and did not meet the minimum requirements for total openable area. In the bedroom occupied by R4 on the main level, the clear openable area of the opened windows measured 11 inches in height and 36 inches in width, with a total openable area of 396 square inches. The windows did not meet the minimum requirements for opening height and did not meet the minimum requirements for total openable area. Egress windows in existing sleeping rooms must have a minimum openable width of 20 inches and minimum openable height of 20 inches with no less than 648 square inches total of openable area (4.5 square feet) for the window. Survey staff explained to LPN-B and RN-C that at least one egress window in each bedroom must be provided to meet the minimum state standard for an egress window to be a complying bedroom for	0 820			

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0 820	Continued From page 14 resident occupancy. LPN-B and RN-C verbally confirmed the findings. On June 17, 2024, at 12:00 p.m., during the interview, survey staff explained to RN-C that an immediate correction order was issued for the above finding. RN-C acknowledged the above finding. No Further information was provided.	0 820			
01290 SS=F	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 interview and record review, the licensee failed to ensure a background study was affiliated with the assisted living facility's health facility identification (HFID) number for two of two employees (unlicensed personnel (ULP)-D, ULP-E). This had the potential to affect all residents living in the facility.	01290			

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01290	Continued From page 15 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: ULP-D ULP-D was hired on August 8, 2017, to provide direct care and services to the facility's residents. ULP-D's employee record contained a Background Study Clearance dated May 11, 2023, from a sister facility. However, the document was not affiliated with the facility's license. ULP-E ULP-E was hired on January 23, 2024, to provide direct care and services to the facility's residents. ULP-E's employee record contained a Background Study Clearance dated January 23, 2024, from a sister facility. However, the document was not affiliated with the facility's license. On June 17, 2024, at 2:35 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated ULP-D and ULP-E's background studies were not affiliated with the facility's license. LALD/CNS-A further stated, she was not aware that each facility had a different HFID number.	01290			

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01290	Continued From page 16 No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290			
01640 SS=D	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 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 observation, interview, and record review, the licensee failed to ensure a written service plan was revised to reflect the current services provided for one of one resident (R1).	01640			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 21887	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/18/2024
NAME OF PROVIDER OR SUPPLIER COMMUNITY ASSISTED LIVING INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1205 6TH AVENUE WEST SHAKOPEE, MN 55379		
(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 17 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1 was admitted on May 9, 2023, with diagnoses that included diabetes and coronary artery disease (damage or disease in the heart's major blood vessels). On June 17, 2024, at 12:14 p.m., the surveyor observed unlicensed personnel (ULP)-D administer medications from a prefilled medication box to R1. R1's service plan dated May 9, 2024, indicated R1 received assistance with dressing, grooming, toileting, bathing, medication administration every shift, blood glucose checks per MD orders, daily weights, lymphedema boots, housekeeping, and laundry. R1's medication administration record (MAR) dated June 1, 2024, through June 30, 2024, indicated R1 received medication administration 5 x/day. The MAR also included weekly medication set up by the nurse. R1's service plan did not include medication set up. On June 18, 2024, at 9:15 a.m., licensed practical nurse (LPN)-B stated R1's service plan did not	01640			

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01640	Continued From page 18 include medication set up. LPN-B further stated R1 received medication administration 5 x/day. The licensee's Service Plan policy dated August 1, 2021, indicated the service plan would include a description of the services that were to be provided based on the most recent assessment and resident preferences. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640			
01710 SS=D	144G.71 Subd. 3 Individualized medication monitoring and reas The assisted living facility must monitor and reassess the resident's medication management services as needed under subdivision 2 when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually. 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) assessed R1's ability to self-administer medications. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the	01710			

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01710	Continued From page 19 situation has occurred only occasionally). The findings include: R1 was admitted on May 9, 2023, with diagnoses that included diabetes and coronary artery disease (damage or disease in the heart's major blood vessels). On June 17, 2024, at 12:14 p.m., the surveyor observed unlicensed personnel (ULP)-D administer medications to R1. R1's service plan dated May 9, 2024, indicated R1 received medication administration. R1's service plan did not include medication set up. R1's physician orders dated May 21, 2024, included: -acetaminophen 1,000 milligrams (mg) by mouth four times a day (pain) -Allopurinol 300 mg by mouth daily (gout) -Aspirin 81 mg by mouth daily (heart health) -Atorvastatin 40 mg by mouth daily (cholesterol) -Cholecalciferol 25 micrograms (mcg) by mouth daily (vitamin d deficiency) -Gabapentin 600 mg by mouth twice daily and 900 mg by mouth at bedtime (neuropathy) -Isosorbide Mononitrate 60 mg by mouth daily (coronary artery disease) -Preservision 1 capsule by mouth twice daily (eye health) -omeprazole 20 mg by mouth daily (heartburn) -Empagliflozine 12.5 mg by mouth daily (diabetes) -Insulin Glargine 22 units daily (diabetes) -Lactose 300 unit by mouth three times a day (lactose intolerance) -Meclizine 12.5 mg by mouth twice daily (dizziness)	01710			

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01710	Continued From page 20 -Metoprolol Tartrate 12.5 mg by mouth twice daily (chest pain) -Methocarbamol 750 mg by mouth three times daily (pain) -furosemide 40 mg by mouth daily (edema) -furosemide 20 mg by mouth as needed once a day if weight is above 170 pounds (edema) -Trazodone 30 mg by mouth every night (sleep) -Miralax 17 grams by mouth once daily as needed (constipation) -Hydroxyzine 25 mg by mouth three times daily as needed (anxiety) -Melatonin 9 mg by mouth every night as needed (sleep) -Albuterol inhaler every four hours as needed (shortness of breath) -Carboxymethylcellulose eye drops five times daily (dry eyes) -Nitroglycerin 0.4 mg as needed (chest pain) -Diclofenac 1% topically three times a day as needed (pain) -Lidocaine patch 5% daily as needed (pain) -Nystatin powder twice a day as needed (skin redness/itching) -Psyllium powder 1 teaspoon by mouth daily (bowel regimen) R1's medication administration record (MAR) dated June 1, 2024, through June 30, 2024, did not include an order for Nystatin powder. R1's Medication Assessment for safety in Self Administration dated May 9, 2024, indicated R1 was unable to apply topical ointments, creams, or trans-dermal patches on his own. It also indicated that R1 was unable to demonstrate secure storage of medications kept in his room. It further indicated under the summary section "Resident is deemed UNABLE to safely self-administer medications".	01710			

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01710	Continued From page 21 R1's Individualized Medication Management Plan dated May 9, 2024, indicated R1's medications were administered by facility staff and medications were stored in a locked medication room. On June 17, 2024, at 12:08 p.m., licensed practical nurse (LPN)-B stated the Nystatin order was not listed on R1's MAR because he kept it in his room and self-administered it. LPN-B reviewed R1's medication assessment and stated it indicated R1 was not able to self-administer the Nystatin or store it in his room. The licensee's Medication Management-Assessment, Monitoring and Reassessment policy dated August 1, 2021, indicated the licensee would monitor and reassess the resident's medication management services as needed when the resident presents with symptoms or other issues that may be medication-related and, at minimum, annually. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days		01710		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the		01760		

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01760	Continued From page 22 reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were administered per prescriber's orders and failed to ensure medication administration was documented accurately for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was admitted on May 9, 2023, with diagnoses that included diabetes and coronary artery disease (damage or disease in the heart's major blood vessels). On June 17, 2024, at 12:14 p.m., the surveyor observed unlicensed personnel (ULP)-D administer medications to R1. R1's service plan dated May 9, 2024, indicated R1 received medication administration.	01760			

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01760	Continued From page 23 FUROSEMIDE: R1's physician orders dated May 21, 2024, included: -Furosemide 40 mg by mouth daily (edema) -Furosemide 20 mg by mouth as needed once a day if weight is above 170 pounds (edema) R1's Weight Sheet dated March 19, 2024, through June 16, 2024, included the following: -On June 3, 2024, R1's weight was 172 lbs. -On June 4, 2024, R1's weight was 170.8 lbs. -On June 5, 2024, R1's weight was 170.6 lbs. -On June 11, 2024, R1's weight was 171 lbs. -On June 12, 2024, R1's weight was 173 lbs. -On June 14, 2024, R1's weight was 171.8 lbs. -On June 15, 2024, R1's weight was 171.8 lbs. -On June 16, 2024, R1's weight was 170.4 lbs. R1's medication administration record (MAR) dated June 1, 2024, through June 30, 2024, indicated R1 received Furosemide 40 mg, by mouth every day at 8:00 a.m. R1's PRN (as needed) MAR dated June 1, 2024, through June 30, 2024, included an order for furosemide 20 mg, take one tablet by mouth in addition to morning dose for weights above 170 lbs, as needed. However, it indicated R1 had not received this medication on the dates listed above when R1's weight was above 170 lbs. MELATONIN: R1's physician orders dated May 21, 2024, included Melatonin 9 mg by mouth every night as needed (sleep). R1's MAR dated June 1, 2024, through June 30, 2024, indicated R1 received Melatonin 9 mg every day at bedtime scheduled.	01760			

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01760	Continued From page 24 PSYLLIUM POWDER: R1's physician orders dated May 21, 2024, included Psyllium powder 1 teaspoon by mouth daily (bowel regimen). R1's MAR dated June 1, 2024, through June 30, 2024, did not include Psyllium powder. On June 17, 2024, at 12:04 p.m., licensed practical nurse (LPN)-B stated R1 should have received the PRN dose of Furosemide when his weight was above 170 lbs and if R1 refused the PRN dose the ULP should have documented the refusal. LPN-B further stated R1 requested Melatonin scheduled to automatically be administered every night instead of PRN, so he didn't have to ask for it every night. LPN-B stated she sent a request to R1's provider to schedule the Melatonin at bedtime but the provider declined that request, and it should remain PRN. However, LPN-B set up the Melatonin to be included with his scheduled bedtime medications. LPN-B stated staff did not document the effectiveness of the Melatonin since it was being administered on a schedule and not PRN. Additionally, LPN-B stated R1 refused to take the Psyllium powder because he didn't like the taste of it, so it was not included on R1's MAR. R1's record lacked evidence of an order to discontinue the Psyllium powder. The licensee's Medication and Treatment Orders policy dated August 1, 2021, indicated current, written prescriber's order must be obtained for any treatment or medication administration provided to the resident. It further indicated the residents MAR would be audited regularly by licensed nurse or designee for documentation compliance.	01760			

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01760	Continued From page 25 No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760			
01770 SS=F	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure documentation of medication setup included all the required content for one of one resident (R1). 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: During the entrance conference on June 17, 2024, at approximately 8:45 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A and licensed practical nurse (LPN)-B stated the licensee provided medication management services to their residents, including	01770			

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01770	Continued From page 26 medication set up for all residents. R1 was admitted on May 9, 2023, with diagnoses that included diabetes and coronary artery disease (damage or disease in the heart's major blood vessels). On June 17, 2024, at 12:14 p.m., the surveyor observed unlicensed personnel (ULP)-D administer medications to R1. R1's service plan dated May 9, 2024, indicated R1 received medication administration; however, it did not include medication set up. R1's physician orders dated May 21, 2024, included: -acetaminophen 1,000 milligrams (mg) by mouth four times a day (pain) -Allopurinol 300 mg by mouth daily (gout) -Aspirin 81 mg by mouth daily (heart health) -Atorvastatin 40 mg by mouth daily (cholesterol) -Cholecalciferol 25 micrograms (mcg) by mouth daily (vitamin d deficiency) -Gabapentin 600 mg by mouth twice daily and 900 mg by mouth at bedtime (neuropathy) -isosorbide mononitrate 60 mg by mouth daily (coronary artery disease) -Preservision 1 capsule by mouth twice daily (eye health) -omeprazole 20 mg by mouth daily (heartburn) -Empagliflozine 12.5 mg by mouth daily (diabetes) -Insulin Glargine 22 units daily (diabetes) -Lactose 300 unit by mouth three times a day (lactose intolerance) -Meclizine 12.5 mg by mouth twice daily (dizziness) -metoprolol tartrate 12.5 mg by mouth twice daily (chest pain)	01770			

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01770	Continued From page 27 -Methocarbamol 750 mg by mouth three times daily (pain) -furosemide 40 mg by mouth daily (edema) -furosemide 20 mg by mouth as needed once a day if weight is above 170 pounds (edema) -Trazodone 30 mg by mouth every night (sleep) -Miralax 17 grams by mouth once daily as needed (constipation) -Hydroxyzine 25 mg by mouth three times daily as needed (anxiety) -Melatonin 9 mg by mouth every night as needed (sleep) -Albuterol inhaler every four hours as needed (shortness of breath) -Carboxymethylcellulose eye drops five times daily (dry eyes) -Nitroglycerin 0.4 mg as needed (chest pain) -Diclofenac 1% topically three times a day as needed (pain) -Lidocaine patch 5% daily as needed (pain) -Nystatin powder twice a day as needed (skin redness/itching) -Psyllium powder 1 teaspoon by mouth daily (bowel regimen) R1's Medication Administration Record (MAR) dated June 1, 2024, through June 30, 2024, included documentation for "dosage boxes, cleaned and filled x 1 week" on June 5, 11 and 17, 2024. R1's record lacked documentation by the licensed nurse at the time of setup to include the name of medication, quantity of dose, times to be administered, and route of administration. On June 18, 2024, at 9:10 a.m., LPN-B stated she completed medication set-up for all residents each week and documented the completion of the medication set up on the residents' MARs.	01770			

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01770	Continued From page 28 LPN-B further stated she did not document the name of the medication, quantity of dose, times to be administered, or route of administration anywhere in the resident record. The licensee's Medication Management- Dosage Box Setup policy dated August 1, 2021, indicated the following: 1. A licensed nurse will assure the medication orders are transcribed onto the MAR. This profile includes: a. Dates of medication set up b. Medication name c. Quantity of dose d. Times to be administered e. Route of administration f. Name of the person completing the medication setup g. Visual description of medication h. Drug classification and special precautions 2. The licensed nurse transcribes the medications order onto the MAR. For medications included in the dosage box, the day and time of administration will be noted on the MAR. 3. Medications that cannot be set up in the dosage box (topical or liquid) will be recorded on the MAR to include any special instructions and: a. Medication name b. Quantity of dose c. Times to be administered d. Route of administration e. Visual description of medication f. Drug classification and special precautions 4. The licensed nurse sets up medication weekly into the dosage boxes. 5. When the licensed nurse has completed setting up the medications into the dosage box, the set-up is documented on the MAR. 6. The licensed nurse will review the dosage boxes on a weekly basis to assure that all the	01770			

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01770	Continued From page 29 previous week's medications were administered, and documentation is then made on the MAR. No further information was provided. TIME PERIOD TO CORRECT: Seven (7) Days	01770			
01790 SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used	01790			

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NAME OF PROVIDER OR SUPPLIER COMMUNITY ASSISTED LIVING INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1205 6TH AVENUE WEST SHAKOPEE, MN 55379		
(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
01790	Continued From page 30 for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) developed training and competencies for two of two unlicensed personnel (ULP-D, ULP-E) providing medications to residents for unplanned time away from home when the licensed nurse was not available. This practice resulted in a level two violation (a	01790			

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01790	Continued From page 31 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: ULP-D ULP-D was hired on August 8, 2017. ULP-D's employee record lacked documentation of training and competencies for unplanned time away when the RN was not available. ULP-E ULP-E was hired on January 23, 2024. ULP-E's employee record lacked documentation of training and competencies for unplanned time away when the RN was not available. On June 18, 2024, at 10:42 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated all ULP were trained, and competency tested on providing medications to residents for unplanned time away, but did not have documentation of the training or competencies. The licensee's Medication Management- Planned and Unplanned Time Away policy dated August 1, 2021, indicated the RN would train the unlicensed staff and determined the unlicensed staff was competent to follow the procedures for giving medications to a resident.	01790			

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01790	Continued From page 32 No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790			
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were secure and permitted access to only authorized personnel. 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: On June 17, 2024, at approximately 9:45 a.m. during the entrance conference, licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated all medications were secured in a locked medication closet which only staff had access to.	01880			

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01880	Continued From page 33 On June 18, 2024, at 8:46 a.m., the surveyor observed a nail attached to trim of the medication closet which had a set of keys hung from the nail. Unlicensed personnel (ULP)-D removed the set of keys from the nail and proceeded to open the medication closet, remove a pre-filled medication box for R1, shut the medication closet door and hang the keys back onto the nail located at the top of the medication closet. ULP-D then brought the medication box to the kitchen to prepare R1's medications for administration. -At 9:02 a.m., ULP-D removed the set of keys hanging on a nail on the medication closet, open the medication closet place R1's medication box back onto a shelf, close the medication closet and hung the keys on the nail. -at this time the surveyor inquired if the keys to the medication closet were always kept hanging on the nail on the outside of the medication closet. ULP-D stated sometimes the ULP carried the keys with them and other times the keys were left on the nail. On June 18, 2024, at 9:47 a.m., licensed practical nurse (LPN)-B stated the keys were often kept on the nail located on the outside of the medication closet because when the staff kept them in their pockets, they risked the staff accidentally leaving the facility with the keys in their pockets. LPN-B further stated when leaving the keys on the nail on the outside of the medication cabinet, the keys were accessible to anyone that walked by the closet. The licensee's Medication Storage policy dated August 1, 2021, indicated medications managed outside of a resident's private "living space" must be in securely locked and substantially constructed compartments and permit only authorized personnel to have access. This may	01880			

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01880	Continued From page 34 be a medication room, medication cart, or similar set up. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880			
01890 SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure insulin syringes had a pharmacy label for the licensee's one resident with insulin (R1). 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: R1 was admitted on May 9, 2023, with diagnoses that included diabetes and coronary artery disease (damage or disease in the heart's major	01890			

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01890	Continued From page 35 blood vessels). R1's service plan dated May 9, 2024, indicated R1 received medication administration. R1's service plan did not include medication set up. R1's physician orders dated May 21, 2024, included: -Insulin Glargine 22 units daily (diabetes) On June 18, 2024, at 9:02 a.m., the surveyor observed unlicensed personnel (ULP)-D remove an unlabeled pre-filled syringe from a lock box located in the medication fridge. ULP-D brought the syringe to R1's room and told R1 the syringe had his insulin in it and gave it to R1 to self-administer. -the surveyor asked ULP-D how she knew who the syringe belonged to and what was in the syringe since it did not have a label on it. ULP-D stated the nurse prefilled each syringe with insulin for R1. ULP-D stated she knew the insulin syringe was for R1 because he was the only resident who received insulin. ULP-D further stated no other resident had medication that was in a syringe. On June 18, 2024, at 9:19 a.m., licensed practical nurse (LPN)-B stated R1's insulin came in vials from the pharmacy and she pre-filled insulin syringes every week for the ULP to use for insulin administration. LPN-B stated the pre-filled syringes did not have a label on them to include the residents name, medication, or direction for use. LPN-B further stated the staff were verbally told that the pre-filled syringes were R1's insulin. The licensee's Insulin policy dated August 1, 2021, indicated the ULP would compare the information of the medication administration record (MAR) with the label on the medication	01890			

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01890	Continued From page 36 container for the following information: -Resident name -Name of the medication -The strength and dosage of the medication -The route -The time that the medication is to be given -Any special instructions If the ULP couldn't read the label, or the MAR and the label did not all say the same thing, stop and call the nurse for instructions. The directions on the label and the MAR should be the same. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890			
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other	01910			

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01910	Continued From page 37 individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document in the resident's record the disposition of the medications as required for one of one resident (R2) upon discharge. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R2 was admitted to the licensee on February 20, 2012, and discharged on December 15, 2023. R2's discharge summary dated December 15, 2023, indicated all medications transferred to the new facility at the time of discharge. R2's record lacked a medication disposition record at the time of discharge to include the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. On June 17, 2024, at 10:18 a.m., licensed practical nurse (LPN)-B stated R2's record lacked a medication disposition record. LPN-B further	01910			

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01910	Continued From page 38 stated she thought a medication disposition record was not necessary since R2 transferred to a sister facility. The licensee's Medication Disposal policy dated June 2021, indicated upon disposition, the facility would document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, date of disposition, and names of staff (including a witness) and other individuals involved in the disposition. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910			
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or	01940			

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01940	Continued From page 39 appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1 was admitted on May 9, 2023, with diagnoses that included diabetes and coronary artery disease (damage or disease in the heart's major blood vessels). On June 18, 2024, at 8:57 a.m., the surveyor observed unlicensed personnel (ULP)-D provide	01940			

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01940	Continued From page 40 verbal cues to R1 while he checked his blood sugar. R1's service plan dated May 9, 2024, indicated R1 received assistance with blood glucose checks per MD orders, daily weights, and lymphedema boots. R1's prescriber orders included: - daily weights, if weight is >170 lbs for three days in a row, or more call the provider; dated September 12, 2023. - lymphedema boots twice daily for one hour; dated September 21, 2023. - accu-check guide (glucose) test strip use one strip four active times a day to check blood sugar; dated May 2, 2023. R1's Individualized Treatment or Therapy Management Plan dated May 9, 2024, failed to include the following required content: -documentation of specific resident instructions relating to the treatments or therapy administration. On June 17, 2024, at 12:56 p.m., licensed practical nurse (LPN)-B stated R1's individualized treatment plan lacked the required content as noted above. The licensee's Treatment and Therapy Management Plan policy dated August 1, 2021, indicated a current individualized treatment and therapy management record for each resident would contain the following: -a statement of the type of services that would be provided -documentation of specific resident instructions relating to the treatments or therapy administration	01940			

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01940	Continued From page 41 -identification of treatment or therapy tasks that would be delegated to unlicensed personnel -procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services -any resident-specific requirements relating to documentation of treatment and therapy received -verification that all treatment and therapy was administered as prescribed -monitoring of treatment or therapy to prevent possible complications on adverse reactions No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940			
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure treatment or therapies were administered as prescribed, or to document the reason they were not provided, for	01960			

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01960	Continued From page 42 one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was admitted on May 9, 2023, with diagnoses that included diabetes and coronary artery disease (damage or disease in the heart's major blood vessels). R1's service plan dated May 9, 2024, indicated R1 received assistance with blood glucose checks per MD orders, daily weights, and lymphedema boots. DAILY WEIGHTS: R1's prescriber orders dated September 12, 2023, included daily weights, if weight is >170 lbs for three days in a row, or more call the provider. R1's Treatment Record dated June 1, 2024, through June 30, 2024, indicated R1 received assistance with daily weights. -On June 1 and 2, 2024, R1 refused to have his weight checked. - June 3, 2024, through June 17, 2024, indicated R1's weight was checked; however, when reviewing the "Weight Sheet" where R1's weight results were documented, the space to document the weight on June 6, 7, 13, 2024, was left blank.	01960			

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NAME OF PROVIDER OR SUPPLIER COMMUNITY ASSISTED LIVING INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1205 6TH AVENUE WEST SHAKOPEE, MN 55379		
(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
01960	Continued From page 43 LYMPHEDEMA BOOTS: R1's prescriber orders dated September 21, 2023, included lymphedema boots twice daily for one hour. R1's Home Health Aide Care Plan record dated June 1, 2024, through June 30, 2024, did not include assistance with lymphedema boots. R1's Treatment Record dated June 1, 2024, through June 30, 2024, did not include assistance with lymphedema boots. BLOOD SUGAR CHECKS: On June 18, 2024, at 8:57 a.m., the surveyor observed unlicensed personnel (ULP)-D provide verbal cues to R1 while he checked his blood sugar. R1's prescriber orders dated May 2, 2023, included accu-check guide (glucose) test strip use one strip four times a day to check blood sugar. R1's Insulin Medication Record dated June 1, 2024, through June 30, 2024, indicated R1's blood sugar was checked once a day before breakfast and as needed per R1's request. On June 17, 2024, at 12:56 p.m., licensed practical nurse (LPN)-B stated R1 frequently refused to use the lymphedema boots. LPN-B further stated R1's record did not have an area for the ULP to document assistance and/or refusal of his lymphedema boots. In addition, LPN-B stated R1's weights were not documented as expected on the dates listed above. LPN-B also stated R1's blood sugar was only checked once per day and as needed.	01960			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 21887	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/18/2024
NAME OF PROVIDER OR SUPPLIER COMMUNITY ASSISTED LIVING INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1205 6TH AVENUE WEST SHAKOPEE, MN 55379		
(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
01960	Continued From page 44 The licensee's Medication and Treatment Record-Documentation and Refusal policy dated August 1, 2021, indicated documentation of medication/treatment/therapy administration would be completed by the person who performed the task immediately after the mediation assistance/administration is completed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960			
03090 SS=C	144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the required notice was posted at the main entry way of the establishment to display statutory language to disclose electronic monitoring activity, potentially affecting all current residents, staff, and any visitors of the facility. This practice resulted in a level one violation (a violation that has not potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive	03090			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 21887	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/18/2024
NAME OF PROVIDER OR SUPPLIER COMMUNITY ASSISTED LIVING INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1205 6TH AVENUE WEST SHAKOPEE, MN 55379			
(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
03090	Continued From page 45 or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The finding include: On June 17, 2024, at approximately 9:30 a.m. upon arriving at the establishment, an observation outside the front entrance, or just inside the front entrance, lacked the required posting for electronic monitoring devices. On June 17, 2024, at 9:54 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the sign had been on the front door but it must have blown off during the recent storm. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	03090			



Minnesota Department of Health
Environmental Health, FPLS
P.O. Box 64975
St. Paul, MN 55164-0975
6512014500

Type: Full
Date: 06/17/24
Time: 13:00:00
Report: 1047241141

Food and Beverage Establishment Inspection Report

Page 1

Location:

Community Assisted Living Inc
1205 6th Avenue West
Shakopee, MN55379
Scott County, 70

Establishment Info:

ID #: 0038656
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 9524403955
ID #:

The violations listed in this report include any previously issued orders and deficiencies identified during this inspection. Compliance dates are shown for each item.

The following orders were issued during this inspection.

4-600 Cleaning Equipment and Utensils

4-601.11C

MN Rule 4626.0840C Clean non-food contact surfaces of equipment and maintain free of accumulations of dust, dirt, food residue, and other debris.

FOOD DEBRIS IN BOTTOM OF SOME DRAWERS & CABINETS. DISCUSSED CLEANING WITH STAFF.

Comply By: 06/17/24

Surface and Equipment Sanitizers

Quaternary Ammonia: = 400 ppm at Degrees Fahrenheit

Location: 3 compartment sink

Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding

Temperature: 36 Degrees Fahrenheit - Location: Main refrigerator- lasagna

Violation Issued: No

Process/Item: Cold Holding

Temperature: 38 Degrees Fahrenheit - Location: Secondary fridge- milk

Violation Issued: No

Type: Full
Date: 06/17/24
Time: 13:00:00
Report: 1047241141
Community Assisted Living Inc

Food and Beverage Establishment Inspection Report

Page 2

Total Orders	In This Report	Priority 1	Priority 2	Priority 3
		0	0	1

The inspection was completed with the operator and reviewed with MDH Nurse Evaluator K. Marking.

The establishment has a residential kitchen and serves food that is prepared that day. The kitchen has laminate cabinets, laminate floor, wall papered walls, solid counter top, and a painted ceiling.

A two basin sink is located in the kitchen. One sink basin is designated for hand washing.

A residential dish machine is located in the kitchen. The facility is currently using quat sanitizer in their sink as the sanitization step. Facility should acquire more temp test strips to verify surface temperature of dishes reaches at least 160F before using new dishwasher to sanitize.

Discussed hand washing, ware washing, staff illness policy, temperature control, final cook temperatures, cleaning, serving highly susceptible populations, and food handling procedures.

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Minnesota Department of Health inspection report number 1047241141 of 06/17/24.

Certified Food Protection Manager Deborah A. Ross

Certification Number: FM1256 Expires: 10/13/26

Inspection report reviewed with person in charge and emailed.

Signed: _____

Jessica Linkey
Operator

Signed: _____

Holly Sievers
Public Health Sanitarian 2
Metro Office
6512015946
Holly.Sievers@state.mn.us