7Electronically Delivered

April 10, 2024

Licensee
Guardian Homes, Inc.
11301 Minnetoka Boulevard
Minnetonka, MN 55305

RE: Project Number(s) SL34908015

Dear Licensee:

On March 19, 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 January 4, 2024. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the January 4, 2024 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on January 4, 2024, found not corrected at the time of the March 19, 2024, follow-up survey and/or subject to penalty assessment are as follows:

0780-Fire Protection And Physical Environment-144g.45 Subd. 2 (a) (1) - $500.00
0790-Fire Protection And Physical Environment-144g.45 Subd. 2 (a) (2)-(3) - $500.00
0800-Fire Protection And Physical Environment-144g.45 Subd. 2 (a) (4) - $500.00
0810-Fire Protection And Physical Environment-144g.45 Subd. 2 (b)-(f) - $500.00

The details of the violations noted at the time of this follow-up survey completed on March 19, 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, **the total amount you are assessed is $2,000.00**. 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.

IMPOSITION OF FINES:

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.

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.

A state correction order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

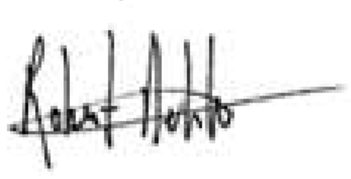
REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd.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

We urge you to review these orders carefully. If you have questions, please contact Bob Dehler at 651-201-3710.

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,



Bob Dehler, P.E.
Engineering Manager
Engineering Services Section
Health Regulation Division
Email: Robert.Dehler@state.mn.us
Telephone: 651-201-3710

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34908	A. BUILDING: _____ B. WING _____	R 03/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN HOMES INC	11301 MINNETOKA BOULEVARD MINNETONKA, MN 55305

(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 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: SL34908015-1 On March 19, 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 January 04, 2024. At the time of the survey, there were 5 residents; 5 receiving services under the Assisted Living license. As a result of the revisit, 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: No further action required.	{0 480}		

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{0 485}	Continued From page 1	{0 485}		
{0 485} SS=C	144G.41 Subdivision 1. (13)(i)(A)and(C) Minimum Requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (A) menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes; and (C) the facility cannot require a resident to include and pay for meals in their contract; (ii) weekly housekeeping; (iii) weekly laundry service; This MN Requirement is not met as evidenced by: No further action required.	{0 485}		
{0 660} SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that	{0 660}		

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{0 660}	Continued From page 2 covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: No further action required.	{0 660}		
{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	{0 680}		

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{0 680}	Continued From page 3 requirements adopted in rule. This MN Requirement is not met as evidenced by: No further action required.	{0 680}		
{0 780} SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that functioned	{0 780}		

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{0 780}	Continued From page 4 and are interconnected so the actuation of one alarm causes all alarms in the dwelling unit to actuate. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On March 19, 2024, at 12:00 p.m., survey staff toured the facility with licensed assisted living director/ unlicensed personnel (LALD/ULP)-D. Survey staff tested the smoke alarms throughout the home. There were two groups of interconnected smoke alarms each consisting of about half of the total smoke alarms in the facility. Upon testing, it was found the smoke alarms in the following locations did not sound when the test button was pressed: 1. Bedroom #1 2. Living Room During interview on March 19, 2024, at 1:30 p.m, LALD/ULP-D stated they thought the maintenance man had been to the facility to fix the issue and they were suprised that the issue was not fixed.	{0 780}		
{0 790} SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment	{0 790}		

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{0 790}	Continued From page 5 (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the portable fire extinguishers. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On March 19, 2024, at 12:00 p.m., survey staff toured the facility with licensed assisted living director/ unlicensed personnel (LALD/ULP)-D. It was observed the portable fire extinguishers throughout the facility lacked records to show the required annual certification and monthly visual inspections were performed on the portable fire	{0 790}		

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{0 790}	Continued From page 6 extinguishers. The lower-level fire extinguisher had a tag for inspections but was empty and did not indicate if an annual inspection had been completed. The main-level fire extinguisher had a certification tag indicating it was last inspected in October 2021. Neither fire extinguisher had a record of monthly inspections. Documentation is required to demonstrate fire extinguishers have been inspected by facility personnel monthly, and annually replaced with a new extinguisher or serviced annually by a certified technician. During interview on March 19, 2024, at 1:30 p.m, survey staff explained to LALD/ULP-D that the portable fire extinguishers must be provided annual certification tags and also monthly visual inspection or "quick checks" of each extinguisher by their employees to ensure all portable extinguishers are readily available, fully charged, and operable at their designated location with no obvious physical damage or condition to the extinguisher that would prevent their operation when needed. LALD/ULP-D verified the findings and stated they understood the requirements.	{0 790}		
{0 800} SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program.	{0 800}		

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{0 800}	Continued From page 7 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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 March 19, 2024, at 12:00 p.m., survey staff toured the facility with licensed assisted living director/ unlicensed personnel (LALD/ULP)-D. The following was observed: Building Maintenance It was observed there was a damaged ceiling tile outside the laundry room. The ceiling tile was broken in half and had dark brown staining on the remaining half. A portion of the tile was falling out of the frame and hanging into the clear opening of the laundry room door. It was observed occupied (R5) resident bedroom #5 in the basement was missing the cover for the overhead light. The light bulbs were exposed to the room.	{0 800}		

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{0 800}	Continued From page 8 It was observed there was a two-inch step between the kitchen area and the living room which was a potential trip hazard. The elevation change was not identified in any way and the pattern of the flooring made it difficult to see. There was adhesive residue on the lower side of the step that suggested a reducer transition strip had been removed at some point. It was observed the ramp at the main entrance/ exit had been disconnected from the outside deck and the pathway to the front door had been blocked by adding two 2x4 pieces of wood across the guardrails to stop people from using the ramp. The distance between the disconnected ramp and the deck was approximately fourteen inches which was not a compliant for egress. During interview on March 19, 2024, at 1:30 p.m. LALD/ULP-D stated they were having difficulty finding a contractor to come out and fix the above listed items. She stated they had success getting the windows installed and the restrictive hardware removed, but have not been able to get the other items fixed yet.	{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 a fire or similar emergency; (3) fire protection procedures necessary for residents; and	{0 810}		

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{0 810}	Continued From page 9 (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 interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required training and drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected	{0 810}		

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{0 810}	Continued From page 10 or has potential to affect a large portion or all of the residents). The findings include: On March 19, 2024, licensed assisted living director/ unlicensed personnel (LALD/ULP)-D provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The licensee's FSEP, titled "9.06 Fire Policy", dated 01/01/2024, and "9.07 Fire Safety, Evacuation Plan, Fire Drills", dated 01/01/2024 failed to include the following: The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate) but failed to include procedures for how staff are to complete each step. The FSEP included standard resident evacuation procedures but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan included instructions to evacuate residents but did not include any procedures for assisting residents during evacuation nor did it include instructions for staff to follow in case of relocation. The FSEP indicated that the "identification of unique or unusual resident needs for movement or	{0 810}		

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{0 810}	Continued From page 11 evacuation will be on resident assessments/ care plan in resident binders and staff are trained on locating such information." Survey staff requested to review one of the assessments/care plans but LALD/ULP-D was not able to locate the document. LALD/ULP-D contacted the registered nurse who also worked at the facility to assist in locating the documentation but she also did not know where the documentation was kept on site. During an interview on March 19, 2024, at 1:00 p.m., LALD/ULP-D stated she understood the areas of her policy that were incomplete and would work on bringing them into compliance. TRAINING Record review indicated the licensee failed to provide evacuation training to residents at least once per year. LALD/ULP-D was unable to provide documentation showing any training offered or training scheduled for a future date for residents on the fire safety and evacuation plan. Record review indicated the licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. LALD/ULP-D was unable to provide documentation showing any training provided or training scheduled for a future date for staff since the date of the last survey. During an interview on March 19, 2024, at 1:00 p.m., LALD/ULP-D stated she had not completed any training since the time of the initial survey, but they were working on developing a training plan and schedule. No further information was provided.	{0 810}		

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	34908	A. BUILDING: _____ B. WING _____	R 03/19/2024

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GUARDIAN HOMES INC	11301 MINNETOKA BOULEVARD MINNETONKA, MN 55305

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{01500}	Continued From page 12	{01500}		
{01500} SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss.	{01500}		

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{01500}	Continued From page 13 Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: No further action required.	{01500}		
{01530} SS=F	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this	{01530}		

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{01530}	Continued From page 14 initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: No further action required.	{01530}		
{01620} SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident	{01620}		

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{01620}	Continued From page 15 of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: No further action required.	{01620}		
{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: No further action required.	{03090}		

Electronically Delivered

February 7, 2024

Licensee
Guardian Homes, Inc.
11301 Minnetoka Boulevard
Minnetonka, MN 55305

RE: Project Number(s) SL34908015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on January 4, 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

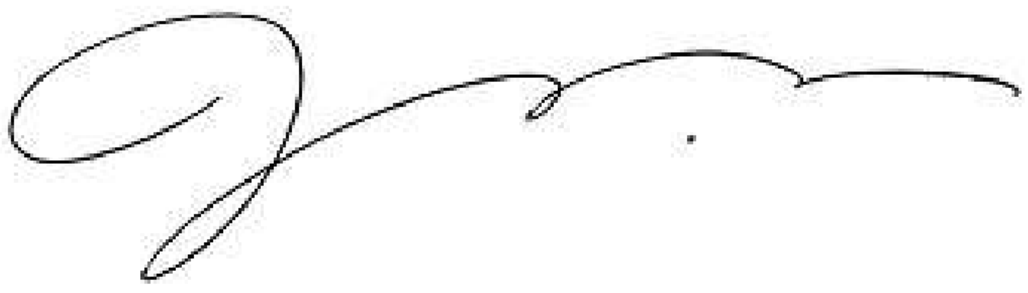
factor. to submit a hearing request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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.

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,



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

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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: SL34908015 On January 2, 2024, through January 4, 2024, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were five active residents receiving services under the assisted living license. An immediate correction order was identified on January 3, 2024, issued for SL34908015-0, tag identification 0820. On January 4, 2023, the immediacy of correction order 0820 was removed; however, non-compliance remained at a level 3/Widespread (I).	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living 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 pursuant to 144G.31 Subd. 1, 2 and 3	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the	0 480		

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0 480	Continued From page 1 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 January 3, 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		
0 485 SS=C	144G.41 Subdivision 1. (13)(i)(A)and(C) Minimum Requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and	0 485		

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0 485	Continued From page 2 fresh vegetables. The following apply: (A) menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes; and (C) the facility cannot require a resident to include and pay for meals in their contract; (ii) weekly housekeeping; (iii) weekly laundry service; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee's assisted living contract required residents to pay for meals. This had the potential to affect all residents. 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: On January 3, 2024, at approximately 11:00 a.m., registered nurse (RN)-E provided a blank Assisted Living Contract and indicated the document was the licensee's assisted living contract used for all residents. Under section III.1.b. (page five (5)), titled Housing Related Services Included in the Monthly Rent," availability of three (3) nutritious meals per	0 485		

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0 485	Continued From page 3 day" was included as part of the monthly fee. The contract lacked an option for residents to opt out of payment for meals residents would not want. On January 3, 2024, at approximately 1:00 p.m., RN-E stated they were unaware the facility could not require a resident to include and pay for meals in their contract and stated they "will need to update their contracts". No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the	0 660		

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0 660	Continued From page 4 licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included baseline screening for one of two employees (unlicensed personnel (ULP)-A). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: The Facility TB Risk Assessment form dated August 1, 2023, identified the facility as a low risk for transmission. ULP-A was hired on July 8, 2021, under the licensee's former comprehensive license and started providing assisted living services August 1, 2021. ULP-A's employee record included a negative lab result for a QuantiFERON TB test dated July 8, 2021. ULP-A's record lacked a TB history and symptom screening at the time of hire. On January 2, 2024, at 1:15 p.m., registered nurse (RN)-E stated they were unable to locate a TB history and screen for ULP-A and stated it "might have been missed". The CDC guideline titled Tuberculosis Screening, Testing, and Treatment of U.S. Health Care Personnel: Recommendations form the National Tuberculosis Controllers Association and CDC,	0 660		

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0 660	Continued From page 5 2019, includes the following updated recommendations: -TB screening with an individual risk assessment and symptom evaluation at baseline; -TB testing with an IGRA or a tuberculosis skin test (TST) for persons without documented prior TB disease or latent TB infection (LTBI); -no routine serial testing at any interval after baseline in the absence of a known exposure or ongoing transmission; -encouragement of treatment for all health care personnel with untreated LTBI; -annual symptom screening for health care personnel with untreated LTBI; and -annual TB education of all personnel. The licensee's 8.16 Tuberculosis Screening policy dated August 1, 2021, indicated new staff would be screened for active signs of TB using the Baseline TB Screening Tool for Healthcare Workers (HCWs). No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
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;	0 680		

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0 680	Continued From page 6 (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 ensure the emergency disaster plan was prominently posted. This had the potential to affect all five residents in the facility, staff, and any 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 January 2, 2024, at approximately 11:00 a.m. observation revealed there was no posted emergency disaster plan inside the facility.	0 680		

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	34908	A. BUILDING: _____ B. WING _____	01/04/2024

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0 680	Continued From page 7 On January 3, 2024, at approximately 10:00 a.m., registered nurse (RN)-E provided a binder labeled Emergency Preparedness Plan. The binder contained a 1.01 Organization Approval and Review and Distribution Plan form dated August 1, 2023. On January 3, 2024, at approximately 1:15 p.m., clinical nurse supervisor (CNS)-C and RN-E stated the EPP had been created on August 1, 2023, and they were unaware of the requirement to post EPP in a prominent area. The licensee's 9.01 Emergency Preparedness Plan-Appendix Z Compliance policy dated August 1, 2021, read "[licensee's] EPP will include all required elements of appendix Z. The plan will be in writing and reviewed annually". No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms;	0 780		

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0 780	Continued From page 8 (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that functioned and are interconnected so the actuation of one alarm causes all alarms in the dwelling unit to actuate. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On January 3, 2024, at 10:30 a.m., survey staff toured the facility with registered nurse (RN)-E. Survey staff tested the smoke alarms throughout the home. There were two groups of	0 780		

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0 780	Continued From page 9 interconnected smoke alarms each consisting of about half of the total smoke alarms in the facility. Upon testing, it was found the smoke alarms in the following locations did not sound when the test button was pressed: 1. Bedroom #1 2. Living Room During interview on January 3, 2024, at 10:30 a.m, RN-E stated they had installed all new smoke alarms, but she did not know why the above-listed locations did not work or how they had two groups of interconnected smoke alarms. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the portable fire extinguishers.	0 790		

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0 790	Continued From page 10 This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 January 3, 2024, at 10:30 a.m., survey staff toured the facility with the registered nurse (RN)-E. It was observed the portable fire extinguishers throughout the facility lacked records to show the required annual certification and monthly visual inspections were performed on the portable fire extinguishers. The lower-level fire extinguisher had a tag for inspections but was empty and did not indicate if an annual inspection had been completed. The main-level fire extinguisher had a certification tag indicating it was last inspected in October 2021. Neither fire extinguisher had a record of monthly inspections. Documentation is required to demonstrate fire extinguishers have been inspected by facility personnel monthly, and annually replaced with a new extinguisher or serviced annually by a certified technician. During interview on January 3, 2024, at 10:30 a.m, survey staff explained to RN-E the portable fire extinguishers must be provided annual certification tags and also monthly visual inspection or "quick checks" of each extinguisher by their employees to ensure all portable	0 790		

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0 790	Continued From page 11 extinguishers are readily available, fully charged, and operable at their designated location with no obvious physical damage or condition to the extinguisher that would prevent their operation when needed. RN-E verified the findings and stated they understood the requirements. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 790		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when	0 800		

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0 800	Continued From page 12 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 January 3, 2024, at 10:30 a.m., survey staff toured the facility with the registered nurse (RN)-E. The following was observed: Egress Windows Survey staff entered occupied (R3) resident bedroom #3 on the main floor to verify if a compliant egress window was present. RN-E attempted to open the window and the survey staff measured the available opening to be 43 inches in height and 23 inches in width with a total openable area of 989 square inches, however, when the window was opened, the hardware for each window obstructed the window from opening completely. There was an additional T-shaped hardware piece attached to the outside of the window frame that only allowed the window to open a few inches. Egress windows must be maintained and able to open completely. Survey staff entered occupied (R4) resident bedroom #4 on the main floor to verify if a compliant egress window was present. RN-E attempted to open the window and the survey staff measured the available opening to be 43 inches in height and 23 inches in width with a total openable area of 989 square inches, however, when the window was opened, the hardware for each window obstructed the window from opening completely. There was an additional T-shaped hardware piece attached to the outside of the window frame that only allowed the window to open a few inches. Egress windows must be maintained and able to open completely.	0 800		

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0 800	Continued From page 13 Building Maintenance It was observed the casement-style window in the lower-level living room was missing the crank and could not be opened from the inside. It was observed there was a damaged ceiling tile outside the laundry room. The ceiling tile was broken in half and had dark brown staining on the remaining half. A portion of the tile was falling out of the frame and hanging into the clear opening of the laundry room door. It was observed the furnace in the garage had a significant leak. The water covered the furnace room floor and was running out of the room from under the door into the garage. On January 3, 2024, at 10:30 a.m., RN-E stated it had been leaking for a while and it was on their list of items to get fixed eventually. It was observed occupied (R5) resident bedroom #5 in the basement was missing the cover for the overhead light. The light bulbs were exposed to the room. It was observed there was a two-inch step between the kitchen area and the living room which was a potential trip hazard. The elevation change was not identified in any way and the pattern of the flooring made it difficult to see. There was adhesive residue on the lower side of the step that suggested a reducer transition strip had been removed at some point. On January 3, 2024, at 10:30 a.m., RN-E stated she did not know if there had been a transition strip, but acknowledged the tripping hazard needed to be mitigated.	0 800		

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0 800	Continued From page 14 It was observed the ramp at the main entrance/ exit had been disconnected from the outside deck and the pathway to the front door had been blocked by adding two 2x4 pieces of wood across the guardrails to stop people from using the ramp. The distance between the disconnected ramp and the deck was approximately fourteen inches which was not a compliant for egress. On January 3, 2024, at 10:30 a.m., RN-E stated they had planned to expand the front deck and install a complete, accessible ramp but the contractor had walked away at the last minute after the existing ramp had been disconnected from the deck. She stated they were planning to find a new contractor and continue the project in the spring. The facility had two other exits, one exit was through the garage, but the door width was only 24 inches and the other was the back door adjacent to the kitchen which was a compliant width for egress. A clear path of egress must be maintained out the back door and around the building to the public way for use by residents and emergency personnel until the main entrance is functional. 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 15 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 interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required training and drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	0 810		

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0 810	Continued From page 16 resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On January 3, 2024, registered nurse (RN)-E provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The licensee's FSEP, titled "9.06 Fire Policy", dated 08/01/2021, failed to include the following: The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate) but the plan was designed for a building with life safety systems such as fire doors and smoke compartments. The policy had not been updated to provide complete actions for employees to take in the event of a fire or similar emergency at the licensed facility which did not have life safety systems or a fire-resistant construction type. The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. The FSEP included standard resident evacuation	0 810		

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0 810	Continued From page 17 procedures but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan included instructions to evacuate residents but did not include any procedures for assisting residents during evacuation nor did it include instructions for staff to follow in case of relocation. During an interview on January 3, 2024, at 1:00 p.m., RN-E stated she had not had an opportunity to update the policy to make it site specific. The policy reviewed was an unedited policy purchased from a third-party provider that was not specific to the facility. TRAINING Record review indicated the licensee failed to provide evacuation training to residents at least once per year. RN-E was unable to provide documentation showing any training offered or training scheduled for a future date for residents on the fire safety and evacuation plan. Record review indicated the licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. RN-E was unable to provide documentation showing any training provided or training scheduled for a future date for staff since the date of the last survey. During an interview on January 3, 2024, at 1:00 p.m., RN-E stated she was doing the training at the same time that she completed the evacuation/ fire drills but was unable to provide any evidence of that. DRILLS Record review indicated the licensee failed to	0 810		

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0 810	Continued From page 18 conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month. Provided documentation indicated that drills were completed on 7/12/23, 9/22/23, and 11/18/2023. During an interview on January 3, 2024, at 1:00 p.m., RN-E stated she had just started doing the evacuation drills the past summer and had no documentation for any drills completed prior to July 2023. 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 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	0 820	This immediate correction order identified on January 3, 2024, had the immediacy removed on January 4, 2024, however non-compliance remained at an scope	

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0 820	Continued From page 19 minimum window opening meeting the minimum state standard for egress. This affected some of the residents in the occupied bedrooms. 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 January 03, 2024, from 10:30 a.m. to 1:00 p.m., survey staff toured the facility with the registered nurse (RN)-E. Occupied Sleeping Rooms: Survey staff asked RN-E to open the windows in occupied (R1) resident bedroom #1 for measurement. RN-E opened the window and the survey staff measured the clear opening to be 16 inches in height and 33 inches in width with a total openable area of 528 square inches. The windows did not meet the minimum requirements for opening height and did not meet the minimum requirements for total openable area. Survey staff asked RN-E to open the windows in occupied (R2) resident bedroom #2 for measurement. RN-E opened the first window and the survey staff measured the clear opening to be 19 inches in height and 25 inches in width with a total openable area of 475 square inches. The windows did not meet the minimum requirements for opening height and did not meet the minimum requirements for total openable area.	0 820	and level of I. This was confirmed by the licensee via email and approved by evaluation supervisor.	

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0 820	Continued From page 20 Unoccupied Sleeping Rooms: Survey staff asked RN-E to open the window in unoccupied resident bedroom #6 for measurement. RN-E opened the window and the survey staff measured the clear opening to be 19 inches in height and 25 inches in width with a total openable area of 475 square inches. The windows did not meet the minimum requirements for opening height and did not meet the minimum requirements for total openable area. Survey staff explained to RN-E 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. RN-E 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. On January 03, 2024, survey staff explained to RN-E that an immediate correction order was issued for the above finding. RN-E acknowledged the above finding. No Further information was provided. TIME PERIOD FOR CORRECTION: Immediate.	0 820		
01500 SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training	01500		

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	34908	A. BUILDING: _____ B. WING _____	01/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01500	Continued From page 21 may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics:	01500		

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01500	Continued From page 22 (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employees received at least eight (8) hours of annual training for each twelve (12) months of employment for one of one employee (unlicensed personnel (ULP)-A). 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 of has the potential to affect a large portion or all of the residents). The findings include: ULP-A was hired July 8, 2021, under the licensee's former comprehensive license and began providing assisted living (AL) services for residents of the facility on August 1, 2021, under the current AL license. ULP-A's employee record lacked documentation	01500		

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01500	Continued From page 23 of eight hours of annual training completed within a 12 month period(between the dates of August 1, 2021, and August 1, 2022), including all content required by Minnesota Statute 144G.63 subdivision 5. On January 3, 2024, at approximately 1:30 p.m., clinical nurse specialist (CNS)-C and registered nurse (RN)-E stated they did not have annual training records for any employees for 2022. The licensee's 5.06 Annual Required Staff Training policy, dated August 1, 2021, indicated, all staff that perform direct care services at [licensee] must complete at least eight (8) hours of annual training for each twelve (12) months of employment and training elements must include: -training on reporting of maltreatment of vulnerable adults under section 626.557; -review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; -review of infection control techniques used in the home and implementation of infection control standards including: - a review of hand washing techniques; -the need for and use of protective gloves, gowns, and masks; -appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; - disinfecting reusable equipment; -disinfecting environmental surfaces; and -reporting of communicable diseases. -effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; -review of the facility's policies and procedures	01500		

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01500	Continued From page 24 relating to the provision of assisted living services and how to implement those policies and procedures; and -principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		
01530 SS=F	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two	01530		

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01530	Continued From page 25 hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employees received at least two (2) hours of training on topics related to dementia for each 12 months of employment after date of hire for one of one employee (unlicensed personnel (ULP)-A) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at 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: ULP-A was hired July 8, 2021, under licensee's former comprehensive license and began providing assisted living (AL)services for residents of the facility on August 1, 2021 under the current AL license. ULP-A's employee record lacked documentation of two hours of training on topics related to dementia between the dates of August 1, 2021, and August 1, 2022. On January 3, 2024, at approximately 1:30 p.m., clinical nurse specialist (CNS)-C and registered nurse (RN)-E stated they did not have annual training records for any employees for 2022.	01530		

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01530	Continued From page 26 The licensee's 5.03 Dementia Training policy dated August 1, 2021, indicated direct care employees will complete eight (8) hours of initial training within 160 hours of the employment start date and will complete 2 hours of additional training for each 12 months of work thereafter. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	01530		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier.	01620		

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01620	Continued From page 27 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing resident monitoring and reassessment to include all areas required on the uniform assessment tool and failed to ensure the comprehensive nursing assessments were completed within the required 90-day timeframe 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 represents a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: R1 was admitted on July 14, 2019, under licensee's former comprehensive license and started receiving assisted living (AL) services on August 1, 2021, under the current AL license. R1's record contained a Uniform Assessment Tool with all required elements completed on July 3, 2023. R1's record also contained an Ongoing Monitoring and Reassessment form indicating an assessment had been completed on October 13, 2023. R1's record lacked a completed Uniform Assessment tool for the assessment completed on October 13, 2023. In addition, the October 13, 2023, assessment was completed 102 days after the July 3, 2023, assessment (12 days late).	01620		

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01620	Continued From page 28 On January 3, 2024, at approximately 10:15 a.m., clinical nurse supervisor (CNS)-D stated they used the Ongoing Monitoring and Reassessment form for all residents, and they were unaware of the requirement of using the uniform assessment tool for all resident assessments and reassessments. The licensee's 6.01 Assessments, Reviews, and Monitoring policy dated August 1, 2021, read "The initial nursing assessment or reassessment must include all the elements of the uniform assessment tool as required, conducted in person, be in writing, dated, and signed by the registered nurse who conducted the assessment". No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
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 and interview, the licensee failed to ensure the required notice was posted at the main entry way of the facility to display statutory language to disclose electronic	03090		

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03090	Continued From page 29 monitoring activity, potentially affecting all current residents in the assisted living facility, staff, and any visitors of the licensee. This practice resulted in a level one violation (a violation that has not potential to cause more than a minimal impact on the client 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 clients). The finding include: On January 2, 2024, at 10:00 a.m. upon arrival to the licensee's facility, the surveyor observed a posting for electronic monitoring devices in the community dining room. The facility lacked posting for electronic monitoring devices at the entrance to the facility. On January 3, 2024, at 11:30 p.m., clinical nurse supervisor (CNS)-C stated they were unaware of required posting of statutory language for electronic monitoring at each facility entrance. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	03090		

Minnesota Department of Health
Food, Pools, & Lodging Services
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *01/03/24*
Time: 10:00:00
Report: 8041241002

Food and Beverage Establishment Inspection Report

Location:
Guardian Homes Inc
11301 Minnetoka Boulevard
Minnetonka, MN55305
Hennepin County, 27

Establishment Info:
ID #: 0038807
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6127020090
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.

2-200 Employee Health

2-201.11C ***** Priority 1 *****

MN Rule 4626.0040C The person in charge must record all reports of diarrhea or vomiting made by food employees and report those illnesses to the regulatory authority.

NO EMPLOYEE ILLNESS LOG ON SITE. EXCLUSION AND LOGGING REQUIREMENTS REVIEWED DURING INSPECTION. MDH LOG FORM SENT WITH REPORT.

Comply By: 01/03/24

3-500C Microbial Control: date marking

3-501.17B ***** Priority 2 *****

MN Rule 4626.0400B Mark the refrigerated, ready-to-eat, TCS food prepared and packaged in a processing plant and opened and held for more than 24 hours in the food establishment using an effective method to indicate the date by which the food must be consumed on the premises, sold, or discarded. The date must not exceed the manufacturer's use-by-date.

MILK AND DELI MEAT THAT WERE OPENED A FEW DAYS AGO NOT DATE MARKED. DATE MARKING REQUIREMENTS REVIEWED DURING INSPECTION AND FACT SHEET PROVIDED.

Comply By: 01/03/24

4-300 Equipment Numbers and Capacities

4-302.13B ***** Priority 2 *****

MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.

NO IRREVERSIBLE REGISTERING TEMPERATURE INDICATOR TO MEASURE THE UTENSIL SURFACE TEMPERATURE IN THE DISH MACHINE ON SITE. THERMAL LABELS PROVIDED DURING INSPECTION.

Comply By: 01/17/24

Type: Full
Date: *01/03/24*
Time: 10:00:00
Report: 8041241002
Guardian Homes Inc

Food and Beverage Establishment Inspection Report

5-200A Plumbing: approved materials/design

5-201.11B

MN Rule 4626.1040B Maintain the plumbing system in good repair.
THE TWO COMPARTMENT FOOD PREP SINK FAUCET IS LEAKING. NEW FAUCET IS ON ORDER.

Comply By: 01/17/24

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 40 Degrees Fahrenheit - Location: LG refrigerator: milk
Violation Issued: No

Process/Item: Cold Holding
Temperature: 39 Degrees Fahrenheit - Location: LG refrigerator: turkey
Violation Issued: No

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

Inspection was completed with the Food Service Manager/Administrator, Naima Ahmed. Michelle Winters was the lead Health Regulation Division Nurse Evaluator. Facility had five residents on site at time of inspections. Meals are prepared on site by staff.

This establishment has a residential kitchen. Food must be prepared for same day service only. The kitchen has cabinetry on stainless legs with a solid surface countertop and tile flooring.

A two basin food prep sink and an additional hand sink are located in the kitchen. Establishment has an NSF residential GE dish machine. Verify the utensil surface temperature is at least 160F using thermal label provided by inspector.

Discussed the following:
-Employee illness policy and logging requirements
-Handwashing
-Glove-use and bare hand contact
-Food storage and preventing cross contamination
-Date marking
-Vomit clean up procedures
-Restrictions concerning serving a highly susceptible population

Type: Full
Date: *01/03/24*
Time: 10:00:00
Report: 8041241002
Guardian Homes Inc

Food and Beverage Establishment Inspection Report

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 8041241002 of 01/03/24.

Certified Food Protection Manager: Naima Ahmed

Certification Number: fm72267 Expires: 10/12/24

Inspection report reviewed with person in charge and emailed.

Signed: _____
Naima Ahmed

Signed: Sarah Conboy
Sarah Conboy
Public Health Sanitarian III
651-201-3984
sarah.conboy@state.mn.us