



*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically Delivered

March 21, 2023

Licensee  
Holistic Health Care Services LLC  
1544 Roundhouse Circle  
Shakopee, MN 55379

RE: Project Number(s) SL38114015

Dear Licensee:

This is your **official notice** that you have been **granted your assisted living facility license**. Your license effective and expiration dates remain the same as on your provisional license. Your updated status will be listed on the license certificate at renewal and **this letter serves as proof** in the meantime. If you have not received a letter from us with information regarding renewing your license within 60 days prior to your expiration date, please contact us at (651) 201-5273 or by email at [Health.assistedliving@state.mn.us](mailto:Health.assistedliving@state.mn.us).

The Minnesota Department of Health completed an initial evaluation on January 24, 2023, for the purpose assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G.

#### **STATE LICENSING ORDERS**

The enclosed State Form documents the state licensing orders. The Department of Health documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Home Care 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 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 . . ."

In accordance with Minn. Stat. § 144G.31, Subd. 4, MDH may assess fines and enforcement actions based on the level and scope of the violations; however, no immediate fines are assessed for this evaluation of your facility.

#### **DOCUMENTATION OF ACTION TO COMPLY**

Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up evaluations. The licensee is not required to submit a plan of correction 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 residents/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 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 the Department of Health within 15 calendar days of the correction order receipt date.

A state licensing 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.

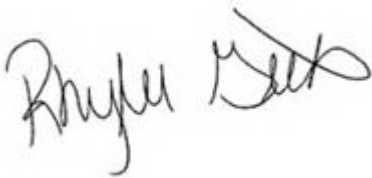
Please email reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

Please address your cover letter for reconsideration requests to:

Reconsideration Unit  
Health Regulation Division  
Minnesota Department of Health  
P.O. Box 64970  
85 East Seventh Place  
St. Paul, MN 55164-0970

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,



Rhylee Gilb,, Supervisor  
State Rapid Response Team  
85 East Seventh Place, Suite 220  
P.O. Box 64970  
St. Paul, MN 55164-0970  
Telephone: 218-232-8285 Fax: 651-215-6894

HHH

Minnesota Department of Health

|                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                        |
|------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>38114</b>                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X3) DATE SURVEY<br>COMPLETED<br><br><b>01/24/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HOLISTIC HEALTH CARE SERVICES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1544 ROUNDHOUSE CIRCLE<br/>SHAKOPEE, MN 55379</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ID<br>PREFIX<br>TAG                                                                           | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (X5)<br>COMPLETE<br>DATE                               |
| 0 000                                                                        | <p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>AMENDED ASSISTED LIVING PROVIDER<br/>LICENSING CORRECTION ORDER</p> <p>In accordance with Minnesota Statutes, section<br/>144G.08 to 144G.95, these correction orders are<br/>issued pursuant to a survey.</p> <p>Determination of whether a violation is corrected<br/>requires compliance with all requirements<br/>provided at the statute number indicated below.<br/>When a Minnesota Statute contains several<br/>items, failure to comply with any of the items will<br/>be considered lack of compliance.</p> <p>INITIAL COMMENTS:</p> <p>SL38114015-0</p> <p>On January 23, 2023 through January 24, 2023,<br/>the Minnesota Department of Health conducted a<br/>survey at the above provider, and the following<br/>correction orders are issued. At the time of the<br/>survey, there were two residents receiving<br/>services under the provider's provisional Assisted<br/>Living license.</p> <p>On February 27, 2023, the enclosed correction<br/>orders were issued to the facility. On March 15,<br/>2023, the correction orders were amended to<br/>change the level for the correction order at tag<br/>identification 0680. No change was made to the<br/>content of any other correction orders, and the<br/>time period for correction on all other orders<br/>continues to run from the original issuance date.</p> <p>On March 20, 2023, the correction orders were<br/>further amended, solely to change the level for</p> | 0 000                                                                                         | <p>Minnesota Department of Health is<br/>documenting the State Licensing<br/>Correction Orders using federal software.<br/>Tag numbers have been assigned to<br/>Minnesota State Statutes for Assisted<br/>Living Facilities. The assigned tag<br/>number appears in the far left column<br/>entitled "ID Prefix Tag." The state Statute<br/>number and the corresponding text of the<br/>state Statute out of compliance is listed in<br/>the "Summary Statement of Deficiencies"<br/>column. This column also includes the<br/>findings which are in violation of the state<br/>requirement after the statement, "This<br/>Minnesota requirement is not met as<br/>evidenced by." Following the evaluators'<br/>findings is the Time Period for Correction.</p> <p>PLEASE DISREGARD THE HEADING OF<br/>THE FOURTH COLUMN WHICH<br/>STATES, "PROVIDER'S PLAN OF<br/>CORRECTION." THIS APPLIES TO<br/>FEDERAL DEFICIENCIES ONLY. THIS<br/>WILL APPEAR ON EACH PAGE.</p> <p>THERE IS NO REQUIREMENT TO<br/>SUBMIT A PLAN OF CORRECTION FOR<br/>VIOLATIONS OF MINNESOTA STATE<br/>STATUTES.</p> <p>THE LETTER IN THE LEFT COLUMN IS<br/>USED FOR TRACKING PURPOSES AND<br/>REFLECTS THE SCOPE AND LEVEL<br/>ISSUED PURSUANT TO 144G.31<br/>SUBDIVISION 1-3.</p> |                                                        |

Minnesota Department of Health  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

|                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                               |                                                                                                                          |                                                        |
|------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>38114</b>                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>01/24/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HOLISTIC HEALTH CARE SERVICES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1544 ROUNDHOUSE CIRCLE<br/>SHAKOPEE, MN 55379</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | ID<br>PREFIX<br>TAG                                                                           | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 0 000                                                                        | Continued From page 1<br><br>correction order 0110. No change was made to the content of any other correction orders, and the time period for correction on all orders continues to run from the original issuance date.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 0 000                                                                                         |                                                                                                                          |                                                        |
| 0 110<br>SS=C                                                                | <p>144G.10 Subdivision 1a Assisted living director license required</p> <p>Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports.?</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on interview and record review, the licensee failed to ensure the Licensed Assisted Living Director (registered nurse (RN)-A) listed herself as the Director of Record for the facility with the Board of Executives for Long-Term Support and Services (BELTSS).</p> <p>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 the potential to affect a large portion or all of the residents).</p> <p>Findings include:</p> <p>RN-A held a current assisted living director license through BELTSS with an expiration date October 31, 2023.</p> <p>At the time of the survey, the BELTSS website did not list the licensee under the Director of Record</p> | 0 110                                                                                         |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                               |                                                                                                                          |                                                        |
|------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>38114</b>                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>01/24/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HOLISTIC HEALTH CARE SERVICES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1544 ROUNDHOUSE CIRCLE<br/>SHAKOPEE, MN 55379</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ID<br>PREFIX<br>TAG                                                                           | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 0 110                                                                        | Continued From page 2<br><br>associated with RN-A's license.<br><br>During the exit conference on January 24, 2023<br>at 12:10 p.m., RN-A acknowledged she had<br>recently learned about this requirement.<br><br>TIME PERIOD FOR CORRECTION: Two (2)<br>Days                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 0 110                                                                                         |                                                                                                                          |                                                        |
| 0 470<br>SS=F                                                                | 144G.41 Subdivision 1 Minimum requirements<br><br>(11) develop and implement a staffing plan for<br>determining its staffing level that:<br>(i) includes an evaluation, to be conducted at<br>least twice a year, of the appropriateness of<br>staffing levels in the facility;<br>(ii) ensures sufficient staffing at all times to meet<br>the scheduled and reasonably foreseeable<br>unscheduled needs of each resident as required<br>by the residents' assessments and service plans<br>on a 24-hour per day basis; and<br>(iii) ensures that the facility can respond promptly<br>and effectively to individual resident emergencies<br>and to emergency, life safety, and disaster<br>situations affecting staff or residents in the facility;<br>(12) ensure that one or more persons are<br>available 24 hours per day, seven days per week,<br>who are responsible for responding to the<br>requests of residents for assistance with health or<br>safety needs. Such persons must be:<br>(i) awake;<br>(ii) located in the same building, in an attached<br>building, or on a contiguous campus with the<br>facility in order to respond within a reasonable<br>amount of time;<br>(iii) capable of communicating with residents;<br>(iv) capable of providing or summoning the<br>appropriate assistance; and<br>(v) capable of following directions; | 0 470                                                                                         |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                               |                                                                                                                          |                                                        |
|------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>38114</b>                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>01/24/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HOLISTIC HEALTH CARE SERVICES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1544 ROUNDHOUSE CIRCLE<br/>SHAKOPEE, MN 55379</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | ID<br>PREFIX<br>TAG                                                                           | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 0 470                                                                        | <p>Continued From page 3</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on interview and record review, the licensee failed to ensure it employed a sufficient number of staff for 24/7 (24 hours per day, seven days per week) care. This had the potential to affect all residents and employees.</p> <p>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).</p> <p>Findings include:</p> <p>During the entrance conference on January 23, 2023 at 10:40 a.m., registered nurse (RN)-A stated the licensee had two twelve hour shifts daily. The day shift ran from 8:00 a.m. to 8:00 p.m., and the night shift ran from 8:00 p.m. to 8:00 a.m.</p> <p>During an interview on January 23, 2023, at 1:45 p.m., RN-A stated the licensee employed three staff members. Unlicensed personnel (ULP)-B worked every night, ULP-C worked every day, and RN-A worked almost every day as well.</p> <p>The staff roster confirmed RN-A, ULP-B, and ULP-C were the only three staff employed by the licensee.</p> <p>The licensee failed to provide a policy regarding staffing.</p> | 0 470                                                                                         |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                               |                                                                                                                          |                                                        |
|------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>38114</b>                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>01/24/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HOLISTIC HEALTH CARE SERVICES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1544 ROUNDHOUSE CIRCLE<br/>SHAKOPEE, MN 55379</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ID<br>PREFIX<br>TAG                                                                           | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 0 470                                                                        | Continued From page 4                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 0 470                                                                                         |                                                                                                                          |                                                        |
| 0 480<br>SS=F                                                                | <p>TIME PERIOD FOR CORRECTION: Seven (7) Days</p> <p>144G.41 Subd 1 (13) (i) (B) Minimum requirements</p> <p>(13) offer to provide or make available at least the following services to residents:<br/>(B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code.</p> <p>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).</p> <p>The findings include:</p> <p>Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated January 23, 2023, for the specific Minnesota Food Code deficiencies.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p> | 0 480                                                                                         |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                               |                                                                                                                          |                                                        |
|------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>38114</b>                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>01/24/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HOLISTIC HEALTH CARE SERVICES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1544 ROUNDHOUSE CIRCLE<br/>SHAKOPEE, MN 55379</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ID<br>PREFIX<br>TAG                                                                           | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 0 490                                                                        | Continued From page 5                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 0 490                                                                                         |                                                                                                                          |                                                        |
| 0 490<br>SS=F                                                                | <p>144G.41 Subd 1 (13) (ii)-(vii) Minimum requirements</p> <p>(iv) upon the request of the resident, provide direct or reasonable assistance with arranging for transportation to medical and social services appointments, shopping, and other recreation, and provide the name of or other identifying information about the persons responsible for providing this assistance;</p> <p>(v) upon the request of the resident, provide reasonable assistance with accessing community resources and social services available in the community, and provide the name of or other identifying information about persons responsible for providing this assistance;</p> <p>(vi) provide culturally sensitive programs; and</p> <p>(vii) have a daily program of social and recreational activities that are based upon individual and group interests, physical, mental, and psychosocial needs, and that creates opportunities for active participation in the community at large; and</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on interview and record review, the licensee failed to provide culturally sensitive programs. This had the potential to affect all residents.</p> <p>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).</p> | 0 490                                                                                         |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                               |                                                                                                                          |                                                        |
|------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>38114</b>                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>01/24/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HOLISTIC HEALTH CARE SERVICES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1544 ROUNDHOUSE CIRCLE<br/>SHAKOPEE, MN 55379</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ID<br>PREFIX<br>TAG                                                                           | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 0 490                                                                        | Continued From page 6<br><br>Findings include:<br><br>During the entrance conference on January 23,<br>2023, registered nurse (RN)-A stated the licensee<br>did not provide culturally sensitive programs, but<br>they could if needed.<br><br>The licensee-provided policy titled Minimum<br>Assisted Living Facility Requirements, undated,<br>indicated the licensee would provide culturally<br>sensitive programs.<br><br>TIME PERIOD FOR CORRECTION: Twenty-One<br>(21) Days                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 0 490                                                                                         |                                                                                                                          |                                                        |
| 0 550<br>SS=C                                                                | 144G.41 Subd. 7 Resident grievances; reporting<br>maltreatment<br><br>All facilities must post in a conspicuous place<br>information about the facilities' grievance<br>procedure, and the name, telephone number, and<br>email contact information for the individuals who<br>are responsible for handling resident grievances.<br>The notice must also have the contact<br>information for the Office of Ombudsman for<br>Long-Term Care and the Office of Ombudsman<br>for Mental Health and Developmental Disabilities<br>and must have information for reporting<br>suspected maltreatment to the Minnesota Adult<br>Abuse Reporting Center. The notice must also<br>state that if an individual has a complaint about<br>the facility or person providing services, the<br>individual may contact the Office of Health Facility<br>Complaints at the Minnesota Department of<br>Health.<br><br>This MN Requirement is not met as evidenced<br>by: | 0 550                                                                                         |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                               |                                                                                                                          |                                                        |
|------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>38114</b>                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>01/24/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HOLISTIC HEALTH CARE SERVICES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1544 ROUNDHOUSE CIRCLE<br/>SHAKOPEE, MN 55379</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ID<br>PREFIX<br>TAG                                                                           | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 0 550                                                                        | <p>Continued From page 7</p> <p>Based on observation and interview the licensee failed to post information about the licensee's grievance procedure, as well as the name, telephone number, and email contact information for the staff responsible for handling resident grievances. This had the potential to affect all residents.</p> <p>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 of the residents).</p> <p>The findings include:</p> <p>During observation on January 23, 2023, the surveyor observed the licensee did not post information about the licensee's grievance procedure, as well as the name, telephone number, and email contact information for the staff responsible for handling resident grievances in a conspicuous place.</p> <p>During the exit interview on January 24, 2023, at 12:10 p.m., registered nurse (RN)-A stated the licensee provided a copy to the residents but did not know it needed to be posted.</p> <p>The licensee failed to provide a policy addressing the posting requirements in accordance with Minnesota (MN) Statute 144G.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-One (21) Days</p> | 0 550                                                                                         |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                               |                                                                                                                          |                                                        |
|------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>38114</b>                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>01/24/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HOLISTIC HEALTH CARE SERVICES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1544 ROUNDHOUSE CIRCLE<br/>SHAKOPEE, MN 55379</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ID<br>PREFIX<br>TAG                                                                           | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 0 570                                                                        | Continued From page 8                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 0 570                                                                                         |                                                                                                                          |                                                        |
| 0 570<br>SS=C                                                                | <p>144G.42 Subdivision 1 Display of license</p> <p>The original current license must be displayed at the main entrance of each assisted living facility. The facility must provide a copy of the license to any person who requests it.</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on observation and record review, the licensee failed to display the original license at the main entrance of the facility.</p> <p>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 the potential to affect a large portion or all the residents).</p> <p>Findings include:</p> <p>During an observation on January 23, 2023 at 12:37 p.m., the licensee did not have the original current license displayed at the main entrance of the facility.</p> <p>The licensee-provided policy titled Display of License, undated, indicated the license would display the current license in a prominent space within the main entryway.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-One (21) Days</p> | 0 570                                                                                         |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                           |                                                                                                                          |  |                                                        |
|------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>38114</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>01/24/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HOLISTIC HEALTH CARE SERVICES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                           | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1544 ROUNDHOUSE CIRCLE<br/>SHAKOPEE, MN 55379</b>                            |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ID<br>PREFIX<br>TAG                                                       | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| 0 630                                                                        | Continued From page 9                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 0 630                                                                     |                                                                                                                          |  |                                                        |
| 0 630<br>SS=D                                                                | <p>144G.42 Subd. 6 (b) Compliance with requirements for reporting ma</p> <p>(b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse.</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on interview and record review, the licensee failed to address the risk for self-abuse in the individualized abuse prevention plan (IAPP) for one of one residents (R1) with records reviewed.</p> <p>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).</p> <p>Findings include:</p> <p>R1 admitted to the licensee December 20, 2022. R1's diagnoses included hypertension, paranoid personality disorder, and depression. R1's service agreement, dated December 20, 2022, indicated R1 received services including behavior</p> | 0 630                                                                     |                                                                                                                          |  |                                                        |

Minnesota Department of Health

|                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                           |                                                                                                                          |  |                                                        |
|------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>38114</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>01/24/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HOLISTIC HEALTH CARE SERVICES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                           | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1544 ROUNDHOUSE CIRCLE<br/>SHAKOPEE, MN 55379</b>                            |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ID<br>PREFIX<br>TAG                                                       | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| 0 630                                                                        | Continued From page 10<br><br>management and safety checks daily.<br><br>R1's IAPP dated December 29, 2022 failed to<br>address R1's risk for self-abuse.<br><br>During the exit conference on January 24, 2023<br>at 12:10 p.m., registered nurse (RN)-A<br>acknowledged this requirement was not met and<br>stated she could add it to the assessment.<br><br>The licensee-provided policy titled Abuse<br>Prevention, undated, indicated the licensee would<br>assess residents to determine vulnerability to<br>abuse or neglect and develop a specific plan to<br>minimize the risk of abuse to the resident. This<br>policy indicated abuse included self-abuse.<br><br>TIME PERIOD FOR CORRECTION: Seven (7)<br>Days | 0 630                                                                     |                                                                                                                          |  |                                                        |
| 0 680<br>SS=F                                                                | 144G.42 Subd. 10 Disaster planning and<br>emergency preparedness<br><br>(a) The facility must meet the following<br>requirements:<br>(1) have a written emergency disaster plan that<br>contains a plan for evacuation, addresses<br>elements of sheltering in place, identifies<br>temporary relocation sites, and details staff<br>assignments in the event of a disaster or an<br>emergency;<br>(2) post an emergency disaster plan prominently;<br>(3) provide building emergency exit diagrams to<br>all residents;<br>(4) post emergency exit diagrams on each floor;<br>and<br>(5) have a written policy and procedure regarding<br>missing residents.                                                               | 0 680                                                                     |                                                                                                                          |  |                                                        |

Minnesota Department of Health

|                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                               |                                                                                                                          |                                                        |
|------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>38114</b>                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>01/24/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HOLISTIC HEALTH CARE SERVICES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1544 ROUNDHOUSE CIRCLE<br/>SHAKOPEE, MN 55379</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ID<br>PREFIX<br>TAG                                                                           | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 0 680                                                                        | <p>Continued From page 11</p> <p>(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.</p> <p>(c) The facility must meet any additional requirements adopted in rule.</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on interview and record review, the licensee failed to ensure its emergency preparedness plan included all required content. This had the potential to affect all residents, staff, and visitors.</p> <p>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).</p> <p>The findings include:</p> <p>The licensee's emergency program (EP) failed to include:</p> <ul style="list-style-type: none"> <li>-how the licensee would coordinate with other health care facilities and the community during emergency or disaster</li> <li>-arrangements/contracts to re-establish utility services</li> <li>- a process for cooperation with local, tribal, regional, State, and Federal EP to maintain</li> </ul> | 0 680                                                                                         |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                               |                                                                                                                          |                                                        |
|------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>38114</b>                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>01/24/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HOLISTIC HEALTH CARE SERVICES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1544 ROUNDHOUSE CIRCLE<br/>SHAKOPEE, MN 55379</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | ID<br>PREFIX<br>TAG                                                                           | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 0 680                                                                        | <p>Continued From page 12</p> <p>integrated response</p> <ul style="list-style-type: none"> <li>-a written communication plan including all required content</li> <li>-policies/procedures related to: <ul style="list-style-type: none"> <li>-minimum food, water, and pharmaceutical supplies</li> <li>-alternate sources of energy</li> <li>-missing residents</li> <li>-system to track the location of on-duty staff and sheltered residents</li> <li>-how the licensee will provide means to shelter in place</li> <li>-system of medical documentation that preserves resident information, protects confidentiality, and secures/ maintains availability of records</li> <li>-use of volunteers and other emergency staffing strategies, including the process/role for integration</li> <li>-for providing care and treatment at alternate care sites under 1135 waiver</li> <li>-a written training and testing program including all requirements for drills and exercises</li> </ul> </li> </ul> <p>The licensee also failed to post the emergency disaster plan prominently.</p> <p>The licensee lacked evidence of making emergency and disaster training available to residents.</p> <p>During an interview on January 24, 2023 at 9:31 a.m., registered nurse (RN)-A stated to coordinate with other facilities, the licensee would call 911. RN-A stated the licensee did not include a process for cooperation with local, tribal, regional, State, and Federal EP, but it could look into it in the future. Regarding a communication plan, RN-A stated she can send out messages to staff using their electronic charting system.</p> | 0 680                                                                                         |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                               |                                                                                                                          |                                                        |
|------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>38114</b>                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>01/24/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HOLISTIC HEALTH CARE SERVICES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1544 ROUNDHOUSE CIRCLE<br/>SHAKOPEE, MN 55379</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | ID<br>PREFIX<br>TAG                                                                           | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 0 680                                                                        | Continued From page 13<br><br>The licensee-provided policy titled Emergency Preparedness, undated, indicated the licensee would have an identified plan in place. This policy indicated the emergency disaster plan would be posted on each floor, and residents would be offered training.<br><br>TIME PERIOD FOR CORRECTION: Twenty-One (21) Days                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 0 680                                                                                         |                                                                                                                          |                                                        |
| 0 780<br>SS=F                                                                | 144G.45 Subd. 2 (a) (1) Fire protection and physical environment<br><br>(a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and:<br><br>(1) for dwellings or sleeping units, as defined in the State Fire Code:<br>(i) provide smoke alarms in each room used for sleeping purposes;<br>(ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms;<br>(iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics;<br>(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<br>(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; | 0 780                                                                                         |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                               |                                                                                                                          |                                                        |
|------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>38114</b>                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>01/24/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HOLISTIC HEALTH CARE SERVICES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1544 ROUNDHOUSE CIRCLE<br/>SHAKOPEE, MN 55379</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | ID<br>PREFIX<br>TAG                                                                           | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 0 780                                                                        | Continued From page 14<br><br>This MN Requirement is not met as evidenced<br>by:<br>Based on observation and interview, the licensee<br>failed to provide smoke alarms that are<br>interconnected so that actuation of one alarm<br>causes all alarms in the dwelling unit to actuate.<br>This deficient condition had the ability to affect all<br>staff and residents.<br><br>This practice resulted in a level two violation (a<br>violation that did not harm a resident's health or<br>safety but had the potential to have harmed a<br>resident's health or safety, but was not likely to<br>cause serious injury, impairment, or death), and<br>was issued at a widespread scope (when<br>problems are pervasive or represent a systemic<br>failure that has affected or has potential to affect<br>a large portion or all of the residents).<br>Findings include:<br><br>On a facility tour with the manager, unlicensed<br>personnel (ULP)-B On January 24, 2023, at<br>approximately 10:00 a.m., it was observed that<br>the sleeping rooms that were equipped with<br>smoke alarms were not interconnected with the<br>smoke alarms the immediately outside of the<br>sleeping room so that actuation of one alarm<br>would cause all alarms to operate. This deficient<br>condition was visually verified by ULP-B<br>accompanying the tour.<br><br>TIME PERIOD FOR CORRECTION: Seven (7)<br>days. | 0 780                                                                                         |                                                                                                                          |                                                        |
| 0 790<br>SS=F                                                                | 144G.45 Subd. 2 (a) (2)-(3) Fire protection and<br>physical environment<br><br>(2) install and maintain portable fire<br>extinguishers in accordance with the State Fire                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 0 790                                                                                         |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                               |                                                                                                                          |                                                        |
|------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>38114</b>                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>01/24/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HOLISTIC HEALTH CARE SERVICES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1544 ROUNDHOUSE CIRCLE<br/>SHAKOPEE, MN 55379</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ID<br>PREFIX<br>TAG                                                                           | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 0 790                                                                        | <p>Continued From page 15</p> <p>Code;</p> <p>(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</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on observation and interview, the licensee failed to maintain fire extinguishers in accordance with MN State Fire Code as required by MN Statute 144G.45 Subd.2 (a)(2). This had the potential to affect all current residents, staff and visitors.</p> <p>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).<br/>Findings include:</p> <p>On January 24, 2023, at approximately 10:00 a.m., survey staff toured the facility with the manager, unlicensed personnel (ULP)-B. During the facility tour, survey staff observed that portable fire extinguishers were not provided with tags or labels from certified service personnel indicating that annual maintenance had been performed. This deficient condition was visually</p> | 0 790                                                                                         |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                               |                                                                                                                          |                                                        |
|------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>38114</b>                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>01/24/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HOLISTIC HEALTH CARE SERVICES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1544 ROUNDHOUSE CIRCLE<br/>SHAKOPEE, MN 55379</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ID<br>PREFIX<br>TAG                                                                           | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 0 790                                                                        | Continued From page 16<br><br>verified by ULP-B accompanying the tour.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one<br>(21) days                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 0 790                                                                                         |                                                                                                                          |                                                        |
| 0 800<br>SS=F                                                                | 144G.45 Subd. 2 (a) (4) Fire protection and<br>physical environment<br><br>(4) keep the physical environment, including<br>walls, floors, ceiling, all furnishings, grounds,<br>systems, and equipment in a continuous state of<br>good repair and operation with regard to the<br>health, safety, comfort, and well-being of the<br>residents in accordance with a maintenance and<br>repair program.<br><br>This MN Requirement is not met as evidenced<br>by:<br>Based on observation and interview, the licensee<br>failed to maintain the physical environment,<br>including walls, floors, ceiling, all furnishings,<br>grounds, systems, and equipment in a continuous<br>state of good repair and operation with regard to<br>the health, safety, comfort, and well-being of the<br>residents. This deficient condition had the ability<br>to affect a limited number of staff and residents.<br><br>This practice resulted in a level two violation (a<br>violation that did not harm a resident's health or<br>safety but had the potential to have harmed a<br>resident 's health or safety, but was not likely to<br>cause serious injury, impairment, or death), and<br>was issued at a widespread scope (when<br>problems are pervasive or represent a systemic<br>failure that has affected or has potential to affect<br>a large portion or all of the residents).<br><br>Findings include: | 0 800                                                                                         |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                               |                                                                                                                          |                                                        |
|------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>38114</b>                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>01/24/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HOLISTIC HEALTH CARE SERVICES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1544 ROUNDHOUSE CIRCLE<br/>SHAKOPEE, MN 55379</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ID<br>PREFIX<br>TAG                                                                           | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 0 800                                                                        | Continued From page 17<br><br>On January 24, 2023, at approximately 10:00 a.m., survey staff toured the facility with the manager, unlicensed personnel (ULP)-B. During the facility tour, survey staff observed following items:<br><br>It was observed that the cabinet over the bathroom sink on the lower level was loosely attached to the wall and an anchoring bolt was missing at one side of the cabinet.<br><br>It was observed that the upper-level deck was covered with snow and the metal gate was frozen shut from built-up snow and ice at the top of the exit stair on the deck. This deck door was identified as an exit on the evacuation plans posted in the facility. This deficient condition was visually verified by ULP-B accompanying the tour.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 0 800                                                                                         |                                                                                                                          |                                                        |
| 0 810<br>SS=F                                                                | 144G.45 Subd. 2 (b)-(f) Fire protection and physical environment<br><br>(b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to:<br>(1) location and number of resident sleeping rooms;<br>(2) employee actions to be taken in the event of a fire or similar emergency;<br>(3) fire protection procedures necessary for residents; and<br>(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                                                                                                                                                                                                        | 0 810                                                                                         |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                               |                                                                                                                          |                                                        |
|------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>38114</b>                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>01/24/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HOLISTIC HEALTH CARE SERVICES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1544 ROUNDHOUSE CIRCLE<br/>SHAKOPEE, MN 55379</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ID<br>PREFIX<br>TAG                                                                           | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 0 810                                                                        | <p>Continued From page 18</p> <p>evacuation.</p> <p>(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.</p> <p>(d) Fire safety and evacuation plans shall be readily available at all times within the facility.</p> <p>(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.</p> <p>(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.</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on observation, interview, and record review, the licensee failed to develop a fire safety and evacuation plan with required elements; failed to provide required employee training on fire safety and evacuation; failed to provide training to residents capable of assisting in their own evacuation and failed to conduct required evacuation drills. This had the potential to affect all staff, residents, and visitors.</p> <p>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</p> | 0 810                                                                                         |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                               |                                                                                                                          |                                                        |
|------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>38114</b>                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>01/24/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HOLISTIC HEALTH CARE SERVICES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1544 ROUNDHOUSE CIRCLE<br/>SHAKOPEE, MN 55379</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ID<br>PREFIX<br>TAG                                                                           | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 0 810                                                                        | <p>Continued From page 19</p> <p>failure that has affected or has potential to affect a large portion or all of the residents).</p> <p>Findings include:</p> <p>An interview and record review of the available documentation were conducted on January 24, 2023, at approximately 10:00 a.m. with the Registered Nurse (RN)-A, manager/unlicensed personnel (ULP)-B on the fire safety and evacuation plan, fire safety and evacuation training for the facility, and fire safety and evacuation drills for the facility. Record review of the available documentation indicated that the fire safety and evacuation plan was not maintained.</p> <p>Review of the available Emergency Preparedness Plan binder indicated that the license did have an unedited copy of the Minnesota Long Term Care Preparedness Tool kits with some provisions for the fire safety requirement. During the interview, RN-A stated that she did not implement the Minnesota Long Term Care Preparedness Tool kits to the facility-specific requirement, and she was not aware of any provisions in the fire safety and evacuation plan for this requirement. RN-A and ULP- B verified that the fire safety and evacuation plan for the facility lacked these provisions.</p> <p>Record review of the Emergency Preparedness Plan provided by RN-A indicated that the plan did not have provisions for employee actions to be taken in the event of a fire or similar emergency, provisions for actions to be taken for residents who are capable of self-evacuation, and procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual</p> | 0 810                                                                                         |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                           |                                                                                                                          |  |                                                        |
|------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>38114</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>01/24/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HOLISTIC HEALTH CARE SERVICES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                           | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1544 ROUNDHOUSE CIRCLE<br/>SHAKOPEE, MN 55379</b>                            |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ID<br>PREFIX<br>TAG                                                       | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| 0 810                                                                        | Continued From page 20<br><br>resident needs for movement or evacuation.<br>During interview, RN-A, and ULP- B stated that<br>the licensee did not have a policy or a fire safety<br>and evacuation plan that included these items.<br>Review of the Emergency Disaster Plan provided<br>by RN-A indicated that all staff receives<br>emergency and disaster training in orientation<br>and annually, not twice per year after initial hire<br>as required by statute. No additional training<br>records were provided.<br><br>Record review of the available documentation did<br>not indicate that the licensee provides annual<br>training to residents who can assist in their own<br>evacuation on the proper actions to take in the<br>event of a fire including movement, evacuation, or<br>relocation as required by statute.<br><br>Review of the Emergency Disaster Plan provided<br>by RN-A indicated that fire drills or other<br>emergency drills are to be conducted every 6<br>months, not every other month as required by<br>statute. The policy also did not make reference to<br>the minimum requirement of twice per year per<br>shift. No documentation of conducted drills was<br>provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one<br>(21) days | 0 810                                                                     |                                                                                                                          |  |                                                        |
| 01460<br>SS=D                                                                | 144G.63 Subdivision 1 Orientation of staff and<br>supervisors<br><br>All staff providing and supervising direct services<br>must complete an orientation to assisted living<br>facility licensing requirements and regulations<br>before providing assisted living services to<br>residents. The orientation may be incorporated<br>into the training required under subdivision 5. The                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 01460                                                                     |                                                                                                                          |  |                                                        |

Minnesota Department of Health

|                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                               |                                                                                                                          |                                                        |
|------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>38114</b>                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>01/24/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HOLISTIC HEALTH CARE SERVICES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1544 ROUNDHOUSE CIRCLE<br/>SHAKOPEE, MN 55379</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ID<br>PREFIX<br>TAG                                                                           | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 01460                                                                        | <p>Continued From page 21</p> <p>orientation need only be completed once for each staff person and is not transferable to another facility.</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on interview and record review, the licensee failed to complete orientation before providing services to residents for one of two staff members (registered nurse (RN)-A) with records reviewed.</p> <p>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).</p> <p>Findings include:</p> <p>RN-A started working at the licensee August 23, 2022. RN-A's employee record lacked evidence of a completed orientation.</p> <p>During the exit interview on January 24, 2023, at 12:10 p.m., RN-A stated if an orientation checklist was not in her file, it probably did not get completed.</p> <p>The licensee-provided policy titled Staff Orientation &amp; Education, undated, indicated all employees attended a general orientation including all required content upon hire and prior to providing services to residents.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-One</p> | 01460                                                                                         |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                               |                                                                                                                          |                                                        |
|------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>38114</b>                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>01/24/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HOLISTIC HEALTH CARE SERVICES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1544 ROUNDHOUSE CIRCLE<br/>SHAKOPEE, MN 55379</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | ID<br>PREFIX<br>TAG                                                                           | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 01460                                                                        | Continued From page 22<br><br>(21) Days                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 01460                                                                                         |                                                                                                                          |                                                        |
| 01610<br>SS=D                                                                | <p>144G.70 Subd. 2 (a-b) Initial reviews, assessments, and monitoring</p> <p>(a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment.</p> <p>(b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan 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. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery.</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on interview and record review, the licensee failed to complete a physical and cognitive assessment on or before move-in for one of one residents (R1) with records reviewed.</p> <p>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).</p> | 01610                                                                                         |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                               |                                                                                                                          |                                                        |
|------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>38114</b>                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>01/24/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HOLISTIC HEALTH CARE SERVICES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1544 ROUNDHOUSE CIRCLE<br/>SHAKOPEE, MN 55379</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ID<br>PREFIX<br>TAG                                                                           | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 01610                                                                        | <p>Continued From page 23</p> <p>Findings include:</p> <p>R1 admitted to the licensee December 20, 2022. R1's diagnoses included hypertension, paranoid personality disorder, and depression. R1's service agreement, dated December 20, 2022, indicated R1 received services including behavior management and safety checks daily. Registered nurse (RN)-A completed R1's assessment on December 21, 2022.</p> <p>R1's record lacked a pre-admission assessment prior to execution of the assisted living contract and move in.</p> <p>During the exit conference on January 24, 2023, at 12:10 p.m., RN-A stated she completed R1's assessment the day after he admitted because the licensee did not know when exactly he would be arriving at the licensee.</p> <p>The licensee-provided policy titled Assessment - Comprehensive Services, undated, indicated the RN would complete an initial assessment within five days of the initiation of services. This assessment did not address the requirement to complete an assessment prior to move-in.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) Days</p> | 01610                                                                                         |                                                                                                                          |                                                        |



*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically Delivered

March 15, 2023

Licensee  
Holistic Health Care Services LLC  
1544 Roundhouse Circle  
Shakopee, MN 55379

RE: Project Number(s) SL38114015

Dear Licensee:

This is your **official notice** that you have been **granted your assisted living facility license**. Your license effective and expiration dates remain the same as on your provisional license. Your updated status will be listed on the license certificate at renewal and **this letter serves as proof** in the meantime. If you have not received a letter from us with information regarding renewing your license within 60 days prior to your expiration date, please contact us at (651) 201-5273 or by email at [Health.assistedliving@state.mn.us](mailto:Health.assistedliving@state.mn.us).

The Minnesota Department of Health completed an initial evaluation on January 24, 2023, for the purpose assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G.

#### **STATE LICENSING ORDERS**

The enclosed State Form documents the state licensing orders. The Department of Health documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Home Care 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 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 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.20, Subd. 4(a)(5), the Department of Health imposes fine amounts of either \$1,000 or \$5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes 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. The Department of Health 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(a)(5)(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 evaluation:

**St - 0 - 0110 - 144g.10 Subdivision 1a - Assisted Living Director License Required - \$500.00**

**The total amount you are assessed is \$500.00.** You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

**DOCUMENTATION OF ACTION TO COMPLY**

Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up evaluations. The licensee is not required to submit a plan of correction 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 residents/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 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 the Department of Health within 15 calendar days of the correction order receipt date.

A state licensing 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.

Please email reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

Please address your cover letter for reconsideration requests to:

Reconsideration Unit  
Health Regulation Division  
Minnesota Department of Health  
P.O. Box 64970  
85 East Seventh Place  
St. Paul, MN 55164-0970

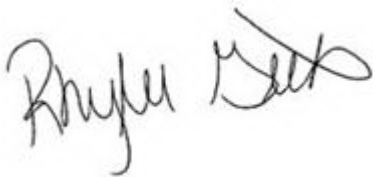
**REQUESTING A HEARING**

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. Requests for hearing may be emailed to: **Health.HRD.Appeals@state.mn.us**.

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.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,

A handwritten signature in black ink, appearing to read "Rhylee Gilb", is written over a light blue horizontal line.

Rhylee Gilb, Supervisor  
Health Regulation Division  
State Rapid Response Team  
P.O. Box 64970  
St. Paul, MN 55164-0970  
Email: [rhylee.gilb@state.mn.us](mailto:rhylee.gilb@state.mn.us)  
Phone: 218-232-8285 Fax: 651-215-6894

HHH

Minnesota Department of Health

|                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                        |
|------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>38114</b>                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X3) DATE SURVEY<br>COMPLETED<br><br><b>01/24/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HOLISTIC HEALTH CARE SERVICES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1544 ROUNDHOUSE CIRCLE<br/>SHAKOPEE, MN 55379</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ID<br>PREFIX<br>TAG                                                                           | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X5)<br>COMPLETE<br>DATE                               |
| 0 000                                                                        | <p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>AMENDED ASSISTED LIVING PROVIDER<br/>LICENSING CORRECTION ORDER</p> <p>In accordance with Minnesota Statutes, section<br/>144G.08 to 144G.95, these correction orders are<br/>issued pursuant to a survey.</p> <p>Determination of whether a violation is corrected<br/>requires compliance with all requirements<br/>provided at the statute number indicated below.<br/>When a Minnesota Statute contains several<br/>items, failure to comply with any of the items will<br/>be considered lack of compliance.</p> <p>INITIAL COMMENTS:</p> <p>SL38114015-0</p> <p>On January 23, 2023 through January 24, 2023,<br/>the Minnesota Department of Health conducted a<br/>survey at the above provider, and the following<br/>correction orders are issued. At the time of the<br/>survey, there were two residents receiving<br/>services under the provider's provisional Assisted<br/>Living license.</p> <p>On February 27, 2023, the enclosed correction<br/>orders were issued to the facility. On March 14,<br/>2023, the correction orders were amended to<br/>change the level for the correction order at tag<br/>identification 0680. No change was made to the<br/>content of any other correction orders, and the<br/>time period for correction on all other orders<br/>continues to run from the original issuance date.</p> | 0 000                                                                                         | <p>Minnesota Department of Health is<br/>documenting the State Licensing<br/>Correction Orders using federal software.<br/>Tag numbers have been assigned to<br/>Minnesota State Statutes for Assisted<br/>Living Facilities. The assigned tag<br/>number appears in the far left column<br/>entitled "ID Prefix Tag." The state Statute<br/>number and the corresponding text of the<br/>state Statute out of compliance is listed in<br/>the "Summary Statement of Deficiencies"<br/>column. This column also includes the<br/>findings which are in violation of the state<br/>requirement after the statement, "This<br/>Minnesota requirement is not met as<br/>evidenced by." Following the evaluators'<br/>findings is the Time Period for Correction.</p> <p>PLEASE DISREGARD THE HEADING OF<br/>THE FOURTH COLUMN WHICH<br/>STATES,"PROVIDER'S PLAN OF<br/>CORRECTION." THIS APPLIES TO<br/>FEDERAL DEFICIENCIES ONLY. THIS<br/>WILL APPEAR ON EACH PAGE.</p> <p>THERE IS NO REQUIREMENT TO<br/>SUBMIT A PLAN OF CORRECTION FOR<br/>VIOLATIONS OF MINNESOTA STATE<br/>STATUTES.</p> <p>THE LETTER IN THE LEFT COLUMN IS<br/>USED FOR TRACKING PURPOSES AND<br/>REFLECTS THE SCOPE AND LEVEL<br/>ISSUED PURSUANT TO 144G.31<br/>SUBDIVISION 1-3.</p> |                                                        |
| 0 110<br>SS=F                                                                | 144G.10 Subdivision 1a Assisted living director<br>license required                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 0 110                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                        |

Minnesota Department of Health  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

|                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                               |                                                                                                                          |                                                        |
|------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>38114</b>                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>01/24/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HOLISTIC HEALTH CARE SERVICES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1544 ROUNDHOUSE CIRCLE<br/>SHAKOPEE, MN 55379</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ID<br>PREFIX<br>TAG                                                                           | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 0 110                                                                        | <p>Continued From page 1</p> <p>Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports.?</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on interview and record review, the licensee failed to ensure the Licensed Assisted Living Director (registered nurse (RN)-A) listed herself as the Director of Record for the facility with the Board of Executives for Long-Term Support and Services (BELTSS).</p> <p>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).</p> <p>Findings include:</p> <p>RN-A held a current assisted living director license through BELTSS with an expiration date October 31, 2023.</p> <p>At the time of the survey, the BELTSS website did not list the licensee under the Director of Record associated with RN-A's license.</p> <p>During the exit conference on January 24, 2023 at 12:10 p.m., RN-A acknowledged she had recently learned about this requirement.</p> <p>TIME PERIOD FOR CORRECTION: Two (2) Days</p> | 0 110                                                                                         |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                               |                                                                                                                          |                                                        |
|------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>38114</b>                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>01/24/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HOLISTIC HEALTH CARE SERVICES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1544 ROUNDHOUSE CIRCLE<br/>SHAKOPEE, MN 55379</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ID<br>PREFIX<br>TAG                                                                           | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 0 470<br>SS=F                                                                | <p>144G.41 Subdivision 1 Minimum requirements</p> <p>(11) develop and implement a staffing plan for determining its staffing level that:</p> <p>(i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility;</p> <p>(ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and</p> <p>(iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility;</p> <p>(12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be:</p> <p>(i) awake;</p> <p>(ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time;</p> <p>(iii) capable of communicating with residents;</p> <p>(iv) capable of providing or summoning the appropriate assistance; and</p> <p>(v) capable of following directions;</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on interview and record review, the licensee failed to ensure it employed a sufficient number of staff for 24/7 (24 hours per day, seven days per week) care. This had the potential to affect all residents and employees.</p> <p>This practice resulted in a level two violation (a</p> | 0 470                                                                                         |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                               |                                                                                                                          |                                                        |
|------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>38114</b>                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>01/24/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HOLISTIC HEALTH CARE SERVICES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1544 ROUNDHOUSE CIRCLE<br/>SHAKOPEE, MN 55379</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ID<br>PREFIX<br>TAG                                                                           | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 0 470                                                                        | Continued From page 3<br><br>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).<br><br>Findings include:<br><br>During the entrance conference on January 23, 2023 at 10:40 a.m., registered nurse (RN)-A stated the licensee had two twelve hour shifts daily. The day shift ran from 8:00 a.m. to 8:00 p.m., and the night shift ran from 8:00 p.m. to 8:00 a.m.<br><br>During an interview on January 23, 2023, at 1:45 p.m., RN-A stated the licensee employed three staff members. Unlicensed personnel (ULP)-B worked every night, ULP-C worked every day, and RN-A worked almost every day as well.<br><br>The staff roster confirmed RN-A, ULP-B, and ULP-C were the only three staff employed by the licensee.<br><br>The licensee failed to provide a policy regarding staffing.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) Days | 0 470                                                                                         |                                                                                                                          |                                                        |
| 0 480<br>SS=F                                                                | 144G.41 Subd 1 (13) (i) (B) Minimum requirements<br><br>(13) offer to provide or make available at least the following services to residents:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 0 480                                                                                         |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                               |                                                                                                                          |                                                        |
|------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>38114</b>                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>01/24/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HOLISTIC HEALTH CARE SERVICES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1544 ROUNDHOUSE CIRCLE<br/>SHAKOPEE, MN 55379</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ID<br>PREFIX<br>TAG                                                                           | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 0 480                                                                        | Continued From page 4<br><br>(B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code.<br><br>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).<br><br>The findings include:<br><br>Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated January 23, 2023, for the specific Minnesota Food Code deficiencies.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 480                                                                                         |                                                                                                                          |                                                        |
| 0 490<br>SS=F                                                                | 144G.41 Subd 1 (13) (ii)-(vii) Minimum requirements<br><br>(iv) upon the request of the resident, provide direct or reasonable assistance with arranging for transportation to medical and social services appointments, shopping, and other recreation, and provide the name of or other identifying information about the persons responsible for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 0 490                                                                                         |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                               |                                                                                                                          |                                                        |
|------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>38114</b>                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>01/24/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HOLISTIC HEALTH CARE SERVICES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1544 ROUNDHOUSE CIRCLE<br/>SHAKOPEE, MN 55379</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | ID<br>PREFIX<br>TAG                                                                           | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 0 490                                                                        | <p>Continued From page 5</p> <p>providing this assistance;<br/>(v) upon the request of the resident, provide reasonable assistance with accessing community resources and social services available in the community, and provide the name of or other identifying information about persons responsible for providing this assistance;<br/>(vi) provide culturally sensitive programs; and<br/>(vii) have a daily program of social and recreational activities that are based upon individual and group interests, physical, mental, and psychosocial needs, and that creates opportunities for active participation in the community at large; and</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on interview and record review, the licensee failed to provide culturally sensitive programs. This had the potential to affect all residents.</p> <p>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).</p> <p>Findings include:</p> <p>During the entrance conference on January 23, 2023, registered nurse (RN)-A stated the licensee did not provide culturally sensitive programs, but they could if needed.</p> <p>The licensee-provided policy titled Minimum Assisted Living Facility Requirements, undated,</p> | 0 490                                                                                         |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                               |                                                                                                                          |                                                        |
|------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>38114</b>                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>01/24/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HOLISTIC HEALTH CARE SERVICES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1544 ROUNDHOUSE CIRCLE<br/>SHAKOPEE, MN 55379</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ID<br>PREFIX<br>TAG                                                                           | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 0 490                                                                        | Continued From page 6<br><br>indicated the licensee would provide culturally sensitive programs.<br><br>TIME PERIOD FOR CORRECTION: Twenty-One (21) Days                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 0 490                                                                                         |                                                                                                                          |                                                        |
| 0 550<br>SS=C                                                                | 144G.41 Subd. 7 Resident grievances; reporting maltreatment<br><br>All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation and interview the licensee failed to post information about the licensee's grievance procedure, as well as the name, telephone number, and email contact information for the staff responsible for handling resident grievances. This had the potential to affect all residents.<br><br>This practice resulted in a level one violation (a | 0 550                                                                                         |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                               |                                                                                                                          |                                                        |
|------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>38114</b>                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>01/24/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HOLISTIC HEALTH CARE SERVICES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1544 ROUNDHOUSE CIRCLE<br/>SHAKOPEE, MN 55379</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ID<br>PREFIX<br>TAG                                                                           | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 0 550                                                                        | Continued From page 7<br><br>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 of the residents).<br><br>The findings include:<br><br>During observation on January 23, 2023, the surveyor observed the licensee did not post information about the licensee's grievance procedure, as well as the name, telephone number, and email contact information for the staff responsible for handling resident grievances in a conspicuous place.<br><br>During the exit interview on January 24, 2023, at 12:10 p.m., registered nurse (RN)-A stated the licensee provided a copy to the residents but did not know it needed to be posted.<br><br>The licensee failed to provide a policy addressing the posting requirements in accordance with Minnesota (MN) Statute 144G.<br><br>TIME PERIOD FOR CORRECTION: Twenty-One (21) Days | 0 550                                                                                         |                                                                                                                          |                                                        |
| 0 570<br>SS=C                                                                | 144G.42 Subdivision 1 Display of license<br><br>The original current license must be displayed at the main entrance of each assisted living facility. The facility must provide a copy of the license to any person who requests it.<br><br>This MN Requirement is not met as evidenced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 0 570                                                                                         |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                               |                                                                                                                          |                                                        |
|------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>38114</b>                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>01/24/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HOLISTIC HEALTH CARE SERVICES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1544 ROUNDHOUSE CIRCLE<br/>SHAKOPEE, MN 55379</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ID<br>PREFIX<br>TAG                                                                           | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 0 570                                                                        | Continued From page 8<br><br>by:<br>Based on observation and record review, the licensee failed to display the original license at the main entrance of the facility.<br><br>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 the potential to affect a large portion or all the residents).<br><br>Findings include:<br><br>During an observation on January 23, 2023 at 12:37 p.m., the licensee did not have the original current license displayed at the main entrance of the facility.<br><br>The licensee-provided policy titled Display of License, undated, indicated the license would display the current license in a prominent space within the main entryway.<br><br>TIME PERIOD FOR CORRECTION: Twenty-One (21) Days | 0 570                                                                                         |                                                                                                                          |                                                        |
| 0 630<br>SS=D                                                                | 144G.42 Subd. 6 (b) Compliance with requirements for reporting ma<br><br>(b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 0 630                                                                                         |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                               |                                                                                                                          |                                                        |
|------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>38114</b>                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>01/24/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HOLISTIC HEALTH CARE SERVICES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1544 ROUNDHOUSE CIRCLE<br/>SHAKOPEE, MN 55379</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ID<br>PREFIX<br>TAG                                                                           | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 0 630                                                                        | <p>Continued From page 9</p> <p>person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse.</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on interview and record review, the licensee failed to address the risk for self-abuse in the individualized abuse prevention plan (IAPP) for one of one residents (R1) with records reviewed.</p> <p>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).</p> <p>Findings include:</p> <p>R1 admitted to the licensee December 20, 2022. R1's diagnoses included hypertension, paranoid personality disorder, and depression. R1's service agreement, dated December 20, 2022, indicated R1 received services including behavior management and safety checks daily.</p> <p>R1's IAPP dated December 29, 2022 failed to address R1's risk for self-abuse.</p> <p>During the exit conference on January 24, 2023 at 12:10 p.m., registered nurse (RN)-A acknowledged this requirement was not met and stated she could add it to the assessment.</p> | 0 630                                                                                         |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                               |                                                                                                                          |                                                        |
|------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>38114</b>                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>01/24/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HOLISTIC HEALTH CARE SERVICES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1544 ROUNDHOUSE CIRCLE<br/>SHAKOPEE, MN 55379</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ID<br>PREFIX<br>TAG                                                                           | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 0 630                                                                        | Continued From page 10<br><br>The licensee-provided policy titled Abuse Prevention, undated, indicated the licensee would assess residents to determine vulnerability to abuse or neglect and develop a specific plan to minimize the risk of abuse to the resident. This policy indicated abuse included self-abuse.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) Days                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 0 630                                                                                         |                                                                                                                          |                                                        |
| 0 680<br>SS=F                                                                | 144G.42 Subd. 10 Disaster planning and emergency preparedness<br><br>(a) The facility must meet the following requirements:<br>(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;<br>(2) post an emergency disaster plan prominently;<br>(3) provide building emergency exit diagrams to all residents;<br>(4) post emergency exit diagrams on each floor; and<br>(5) have a written policy and procedure regarding missing residents.<br>(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.<br>(c) The facility must meet any additional | 0 680                                                                                         |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                               |                                                                                                                          |                                                        |
|------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>38114</b>                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>01/24/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HOLISTIC HEALTH CARE SERVICES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1544 ROUNDHOUSE CIRCLE<br/>SHAKOPEE, MN 55379</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | ID<br>PREFIX<br>TAG                                                                           | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 0 680                                                                        | <p>Continued From page 11</p> <p>requirements adopted in rule.</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on interview and record review, the licensee failed to ensure its emergency preparedness plan included all required content. This had the potential to affect all residents, staff, and visitors.</p> <p>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).</p> <p>The findings include:</p> <p>The licensee's emergency program (EP) failed to include:</p> <ul style="list-style-type: none"> <li>-how the licensee would coordinate with other health care facilities and the community during emergency or disaster</li> <li>-arrangements/contracts to re-establish utility services</li> <li>- a process for cooperation with local, tribal, regional, State, and Federal EP to maintain integrated response</li> <li>-a written communication plan including all required content</li> <li>-policies/procedures related to: <ul style="list-style-type: none"> <li>-minimum food, water, and pharmaceutical supplies</li> <li>-alternate sources of energy</li> <li>-missing residents</li> <li>-system to track the location of on-duty staff and</li> </ul> </li> </ul> | 0 680                                                                                         |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                               |                                                                                                                          |                                                        |
|------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>38114</b>                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>01/24/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HOLISTIC HEALTH CARE SERVICES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1544 ROUNDHOUSE CIRCLE<br/>SHAKOPEE, MN 55379</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ID<br>PREFIX<br>TAG                                                                           | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 0 680                                                                        | <p>Continued From page 12</p> <p>sheltered residents<br/>-how the licensee will provide means to shelter in place<br/>-system of medical documentation that preserves resident information, protects confidentiality, and secures/ maintains availability of records<br/>-use of volunteers and other emergency staffing strategies, including the process/role for integration<br/>-for providing care and treatment at alternate care sites under 1135 waiver<br/>-a written training and testing program including all requirements for drills and exercises</p> <p>The licensee also failed to post the emergency disaster plan prominently.</p> <p>The licensee lacked evidence of making emergency and disaster training available to residents.</p> <p>During an interview on January 24, 2023 at 9:31 a.m., registered nurse (RN)-A stated to coordinate with other facilities, the licensee would call 911. RN-A stated the licensee did not include a process for cooperation with local, tribal, regional, State, and Federal EP, but it could look into it in the future. Regarding a communication plan, RN-A stated she can send out messages to staff using their electronic charting system.</p> <p>The licensee-provided policy titled Emergency Preparedness, undated, indicated the licensee would have an identified plan in place. This policy indicated the emergency disaster plan would be posted on each floor, and residents would be offered training.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-One (21) Days</p> | 0 680                                                                                         |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                               |                                                                                                                          |                                                        |
|------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>38114</b>                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>01/24/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HOLISTIC HEALTH CARE SERVICES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1544 ROUNDHOUSE CIRCLE<br/>SHAKOPEE, MN 55379</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ID<br>PREFIX<br>TAG                                                                           | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 0 780<br>SS=F                                                                | <p>144G.45 Subd. 2 (a) (1) Fire protection and physical environment</p> <p>(a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and:</p> <p>(1) for dwellings or sleeping units, as defined in the State Fire Code:</p> <p>(i) provide smoke alarms in each room used for sleeping purposes;</p> <p>(ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms;</p> <p>(iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics;</p> <p>(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</p> <p>(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;</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on observation and interview, the licensee failed to provide smoke alarms that are interconnected so that 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.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or</p> | 0 780                                                                                         |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                               |                                                                                                                          |                                                        |
|------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>38114</b>                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>01/24/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HOLISTIC HEALTH CARE SERVICES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1544 ROUNDHOUSE CIRCLE<br/>SHAKOPEE, MN 55379</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ID<br>PREFIX<br>TAG                                                                           | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 0 780                                                                        | Continued From page 14<br><br>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).<br>Findings include:<br><br>On a facility tour with the manager, unlicensed personnel (ULP)-B On January 24, 2023, at approximately 10:00 a.m., it was observed that the sleeping rooms that were equipped with smoke alarms were not interconnected with the smoke alarms the immediately outside of the sleeping room so that actuation of one alarm would cause all alarms to operate. This deficient condition was visually verified by ULP-B accompanying the tour.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days. | 0 780                                                                                         |                                                                                                                          |                                                        |
| 0 790<br>SS=F                                                                | 144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment<br><br>(2) install and maintain portable fire extinguishers in accordance with the State Fire Code;<br><br>(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                                                                                         |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                           |                                                                                                                          |  |                                                        |
|------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>38114</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>01/24/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HOLISTIC HEALTH CARE SERVICES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                           | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1544 ROUNDHOUSE CIRCLE<br/>SHAKOPEE, MN 55379</b>                            |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ID<br>PREFIX<br>TAG                                                       | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| 0 790                                                                        | Continued From page 15<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation and interview, the licensee failed to maintain fire extinguishers in accordance with MN State Fire Code as required by MN Statute 144G.45 Subd.2 (a)(2). This had the potential to affect all current residents, staff and visitors.<br><br>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).<br>Findings include:<br><br>On January 24, 2023, at approximately 10:00 a.m., survey staff toured the facility with the manager, unlicensed personnel (ULP)-B. During the facility tour, survey staff observed that portable fire extinguishers were not provided with tags or labels from certified service personnel indicating that annual maintenance had been performed. This deficient condition was visually verified by ULP-B accompanying the tour.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 790                                                                     |                                                                                                                          |  |                                                        |
| 0 800<br>SS=F                                                                | 144G.45 Subd. 2 (a) (4) Fire protection and physical environment<br><br>(4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 0 800                                                                     |                                                                                                                          |  |                                                        |

Minnesota Department of Health

|                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                               |                                                                                                                          |                                                        |
|------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>38114</b>                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>01/24/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HOLISTIC HEALTH CARE SERVICES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1544 ROUNDHOUSE CIRCLE<br/>SHAKOPEE, MN 55379</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ID<br>PREFIX<br>TAG                                                                           | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 0 800                                                                        | <p>Continued From page 16</p> <p>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.</p> <p>This MN Requirement is not met as evidenced by:<br/>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 ability to affect a limited number of staff and residents.</p> <p>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).</p> <p>Findings include:</p> <p>On January 24, 2023, at approximately 10:00 a.m., survey staff toured the facility with the manager, unlicensed personnel (ULP)-B. During the facility tour, survey staff observed following items:</p> <p>It was observed that the cabinet over the bathroom sink on the lower level was loosely attached to the wall and an anchoring bolt was missing at one side of the cabinet.</p> | 0 800                                                                                         |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                               |                                                                                                                          |                                                        |
|------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>38114</b>                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>01/24/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HOLISTIC HEALTH CARE SERVICES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1544 ROUNDHOUSE CIRCLE<br/>SHAKOPEE, MN 55379</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ID<br>PREFIX<br>TAG                                                                           | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 0 800                                                                        | Continued From page 17<br><br>It was observed that the upper-level deck was covered with snow and the metal gate was frozen shut from built-up snow and ice at the top of the exit stair on the deck. This deck door was identified as an exit on the evacuation plans posted in the facility. This deficient condition was visually verified by ULP-B accompanying the tour.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 0 800                                                                                         |                                                                                                                          |                                                        |
| 0 810<br>SS=F                                                                | 144G.45 Subd. 2 (b)-(f) Fire protection and physical environment<br><br>(b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to:<br>(1) location and number of resident sleeping rooms;<br>(2) employee actions to be taken in the event of a fire or similar emergency;<br>(3) fire protection procedures necessary for residents; and<br>(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.<br>(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.<br>(d) Fire safety and evacuation plans shall be readily available at all times within the facility.<br>(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 | 0 810                                                                                         |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                               |                                                                                                                          |                                                        |
|------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>38114</b>                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>01/24/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HOLISTIC HEALTH CARE SERVICES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1544 ROUNDHOUSE CIRCLE<br/>SHAKOPEE, MN 55379</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | ID<br>PREFIX<br>TAG                                                                           | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 0 810                                                                        | <p>Continued From page 18</p> <p>training shall be made available to residents at least once per year.</p> <p>(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.</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on observation, interview, and record review, the licensee failed to develop a fire safety and evacuation plan with required elements; failed to provide required employee training on fire safety and evacuation; failed to provide training to residents capable of assisting in their own evacuation and failed to conduct required evacuation drills. This had the potential to affect all staff, residents, and visitors.</p> <p>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).</p> <p>Findings include:</p> <p>An interview and record review of the available documentation were conducted on January 24, 2023, at approximately 10:00 a.m. with the Registered Nurse (RN)-A, manager/unlicensed personnel (ULP)-B on the fire safety and evacuation plan, fire safety and evacuation</p> | 0 810                                                                                         |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                               |                                                                                                                          |                                                        |
|------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>38114</b>                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>01/24/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HOLISTIC HEALTH CARE SERVICES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1544 ROUNDHOUSE CIRCLE<br/>SHAKOPEE, MN 55379</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ID<br>PREFIX<br>TAG                                                                           | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 0 810                                                                        | <p>Continued From page 19</p> <p>training for the facility, and fire safety and evacuation drills for the facility. Record review of the available documentation indicated that the fire safety and evacuation plan was not maintained.</p> <p>Review of the available Emergency Preparedness Plan binder indicated that the license did have an unedited copy of the Minnesota Long Term Care Preparedness Tool kits with some provisions for the fire safety requirement. During the interview, RN-A stated that she did not implement the Minnesota Long Term Care Preparedness Tool kits to the facility-specific requirement, and she was not aware of any provisions in the fire safety and evacuation plan for this requirement. RN-A and ULP- B verified that the fire safety and evacuation plan for the facility lacked these provisions.</p> <p>Record review of the Emergency Preparedness Plan provided by RN-A indicated that the plan did not have provisions for employee actions to be taken in the event of a fire or similar emergency, provisions for actions to be taken for residents who are capable of self-evacuation, and 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. During interview, RN-A, and ULP- B stated that the licensee did not have a policy or a fire safety and evacuation plan that included these items. Review of the Emergency Disaster Plan provided by RN-A indicated that all staff receives emergency and disaster training in orientation and annually, not twice per year after initial hire as required by statute. No additional training records were provided.</p> | 0 810                                                                                         |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                               |                                                                                                                          |                                                        |
|------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>38114</b>                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>01/24/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HOLISTIC HEALTH CARE SERVICES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1544 ROUNDHOUSE CIRCLE<br/>SHAKOPEE, MN 55379</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ID<br>PREFIX<br>TAG                                                                           | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 0 810                                                                        | Continued From page 20<br><br>Record review of the available documentation did not indicate that the licensee provides annual training to residents who can assist in their own evacuation on the proper actions to take in the event of a fire including movement, evacuation, or relocation as required by statute.<br><br>Review of the Emergency Disaster Plan provided by RN-A indicated that fire drills or other emergency drills are to be conducted every 6 months, not every other month as required by statute. The policy also did not make reference to the minimum requirement of twice per year per shift. No documentation of conducted drills was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days              | 0 810                                                                                         |                                                                                                                          |                                                        |
| 01460<br>SS=D                                                                | 144G.63 Subdivision 1 Orientation of staff and supervisors<br><br>All staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. The orientation may be incorporated into the training required under subdivision 5. The orientation need only be completed once for each staff person and is not transferable to another facility.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to complete orientation before providing services to residents for one of two staff members (registered nurse (RN)-A) with records reviewed. | 01460                                                                                         |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                               |                                                                                                                          |                                                        |
|------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>38114</b>                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>01/24/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HOLISTIC HEALTH CARE SERVICES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1544 ROUNDHOUSE CIRCLE<br/>SHAKOPEE, MN 55379</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ID<br>PREFIX<br>TAG                                                                           | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 01460                                                                        | Continued From page 21<br><br>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).<br><br>Findings include:<br><br>RN-A started working at the licensee August 23, 2022. RN-A's employee record lacked evidence of a completed orientation.<br><br>During the exit interview on January 24, 2023, at 12:10 p.m., RN-A stated if an orientation checklist was not in her file, it probably did not get completed.<br><br>The licensee-provided policy titled Staff Orientation & Education, undated, indicated all employees attended a general orientation including all required content upon hire and prior to providing services to residents.<br><br>TIME PERIOD FOR CORRECTION: Twenty-One (21) Days | 01460                                                                                         |                                                                                                                          |                                                        |
| 01610<br>SS=D                                                                | 144G.70 Subd. 2 (a-b) Initial reviews, assessments, and monitoring<br><br>(a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment.<br>(b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 01610                                                                                         |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                               |                                                                                                                          |                                                        |
|------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>38114</b>                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>01/24/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HOLISTIC HEALTH CARE SERVICES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1544 ROUNDHOUSE CIRCLE<br/>SHAKOPEE, MN 55379</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ID<br>PREFIX<br>TAG                                                                           | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 01610                                                                        | <p>Continued From page 22</p> <p>physical and cognitive needs of the prospective resident and propose a temporary service plan 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. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery.</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on interview and record review, the licensee failed to complete a physical and cognitive assessment on or before move-in for one of one residents (R1) with records reviewed.</p> <p>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).</p> <p>Findings include:</p> <p>R1 admitted to the licensee December 20, 2022. R1's diagnoses included hypertension, paranoid personality disorder, and depression. R1's service agreement, dated December 20, 2022, indicated R1 received services including behavior management and safety checks daily. Registered nurse (RN)-A completed R1's assessment on December 21, 2022.</p> | 01610                                                                                         |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                           |                                                                                                                          |                          |                                                        |
|------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>38114</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>01/24/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HOLISTIC HEALTH CARE SERVICES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                           | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1544 ROUNDHOUSE CIRCLE<br/>SHAKOPEE, MN 55379</b>                            |                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | ID<br>PREFIX<br>TAG                                                       | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                        |
| 01610                                                                        | <p>Continued From page 23</p> <p>R1's record lacked a pre-admission assessment prior to execution of the assisted living contract and move in.</p> <p>During the exit conference on January 24, 2023, at 12:10 p.m., RN-A stated she completed R1's assessment the day after he admitted because the licensee did not know when exactly he would be arriving at the licensee.</p> <p>The licensee-provided policy titled Assessment - Comprehensive Services, undated, indicated the RN would complete an initial assessment within five days of the initiation of services. This assessment did not address the requirement to complete an assessment prior to move-in.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) Days</p> | 01610                                                                     |                                                                                                                          |                          |                                                        |



*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically Delivered

February 27, 2023

Licensee  
Holistic Health Care Services LLC  
1544 Roundhouse Circle  
Shakopee, MN 55379

RE: Project Number(s) SL38114015

Dear Licensee:

This is your **official notice** that you have been **granted your assisted living facility license**. Your license effective and expiration dates remain the same as on your provisional license. Your updated status will be listed on the license certificate at renewal and **this letter serves as proof** in the meantime. If you have not received a letter from us with information regarding renewing your license within 60 days prior to your expiration date, please contact us at (651) 201-5273 or by email at [Health.assistedliving@state.mn.us](mailto:Health.assistedliving@state.mn.us).

The Minnesota Department of Health completed an initial evaluation on January 24, 2023, for the purpose assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G.

#### **STATE LICENSING ORDERS**

The enclosed State Form documents the state licensing orders. The Department of Health documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Home Care 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 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 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.20, Subd. 4(a)(5), the Department of Health imposes fine amounts of either \$1,000 or \$5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes 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. The Department of Health 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(a)(5)(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 evaluation:

**St - 0 - 0110 - 144g.10 Subdivision 1a - Assisted Living Director License Required - \$500.00**

**St - 0 - 0680 - 144g.42 Subd. 10 - Disaster Planning And Emergency Preparedness - \$3,000.00**

**The total amount you are assessed is \$3,500.00.** You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

#### **DOCUMENTATION OF ACTION TO COMPLY**

Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up evaluations. The licensee is not required to submit a plan of correction 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 residents/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 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 the Department of Health within 15 calendar days of the correction order receipt date.

A state licensing 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.

Please email reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

Please address your cover letter for reconsideration requests to:

Reconsideration Unit  
Health Regulation Division  
Minnesota Department of Health  
P.O. Box 64970  
85 East Seventh Place  
St. Paul, MN 55164-0970

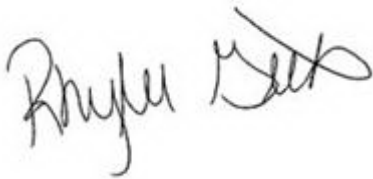
**REQUESTING A HEARING**

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. Requests for hearing may be emailed to: **Health.HRD.Appeals@state.mn.us**.

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.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,



Rhylee Gilb, Supervisor  
Health Regulation Division  
State Rapid Response Team  
85 East Seventh Place, Suite 220  
P.O. Box 64970  
St. Paul, MN 55164-0970  
Email: [rhylee.gilb@state.mn.us](mailto:rhylee.gilb@state.mn.us)  
Phone: 651-201-5977 Fax: 651-215-6894

HHH

Minnesota Department of Health

|                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                        |
|------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>38114</b>                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X3) DATE SURVEY<br>COMPLETED<br><br><b>01/24/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HOLISTIC HEALTH CARE SERVICES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1544 ROUNDHOUSE CIRCLE<br/>SHAKOPEE, MN 55379</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ID<br>PREFIX<br>TAG                                                                           | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (X5)<br>COMPLETE<br>DATE                               |
| 0 000                                                                        | <p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>ASSISTED LIVING PROVIDER LICENSING<br/>CORRECTION ORDER</p> <p>In accordance with Minnesota Statutes, section<br/>144G.08 to 144G.95, these correction orders are<br/>issued pursuant to a complaint investigation.</p> <p>Determination of whether a violation is corrected<br/>requires compliance with all requirements<br/>provided at the statute number indicated below.<br/>When a Minnesota Statute contains several<br/>items, failure to comply with any of the items will<br/>be considered lack of compliance.</p> <p>INITIAL COMMENTS:</p> <p>SL38114015-0</p> <p>On January 23, 2023 through January 24, 2023,<br/>the Minnesota Department of Health conducted a<br/>survey at the above provider, and the following<br/>correction orders are issued. At the time of the<br/>survey, there were two residents receiving<br/>services under the provider's provisional Assisted<br/>Living license.</p> | 0 000                                                                                         | <p>Minnesota Department of Health is<br/>documenting the State Licensing<br/>Correction Orders using federal software.<br/>Tag numbers have been assigned to<br/>Minnesota State Statutes for Assisted<br/>Living Facilities. The assigned tag<br/>number appears in the far left column<br/>entitled "ID Prefix Tag." The state Statute<br/>number and the corresponding text of the<br/>state Statute out of compliance is listed in<br/>the "Summary Statement of Deficiencies"<br/>column. This column also includes the<br/>findings which are in violation of the state<br/>requirement after the statement, "This<br/>Minnesota requirement is not met as<br/>evidenced by." Following the evaluators'<br/>findings is the Time Period for Correction.</p> <p>PLEASE DISREGARD THE HEADING OF<br/>THE FOURTH COLUMN WHICH<br/>STATES, "PROVIDER'S PLAN OF<br/>CORRECTION." THIS APPLIES TO<br/>FEDERAL DEFICIENCIES ONLY. THIS<br/>WILL APPEAR ON EACH PAGE.</p> <p>THERE IS NO REQUIREMENT TO<br/>SUBMIT A PLAN OF CORRECTION FOR<br/>VIOLATIONS OF MINNESOTA STATE<br/>STATUTES.</p> <p>THE LETTER IN THE LEFT COLUMN IS<br/>USED FOR TRACKING PURPOSES AND<br/>REFLECTS THE SCOPE AND LEVEL<br/>ISSUED PURSUANT TO 144G.31<br/>SUBDIVISION 1-3.</p> |                                                        |
| 0 110<br>SS=F                                                                | 144G.10 Subdivision 1a Assisted living director<br>license required                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 0 110                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                        |

Minnesota Department of Health  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

|                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                               |                                                                                                                          |                                                        |
|------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>38114</b>                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>01/24/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HOLISTIC HEALTH CARE SERVICES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1544 ROUNDHOUSE CIRCLE<br/>SHAKOPEE, MN 55379</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ID<br>PREFIX<br>TAG                                                                           | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 0 110                                                                        | <p>Continued From page 1</p> <p>Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports.?</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on interview and record review, the licensee failed to ensure the Licensed Assisted Living Director (registered nurse (RN)-A) listed herself as the Director of Record for the facility with the Board of Executives for Long-Term Support and Services (BELTSS).</p> <p>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).</p> <p>Findings include:</p> <p>RN-A held a current assisted living director license through BELTSS with an expiration date October 31, 2023.</p> <p>At the time of the survey, the BELTSS website did not list the licensee under the Director of Record associated with RN-A's license.</p> <p>During the exit conference on January 24, 2023 at 12:10 p.m., RN-A acknowledged she had recently learned about this requirement.</p> <p>TIME PERIOD FOR CORRECTION: Two (2) Days</p> | 0 110                                                                                         |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                               |                                                                                                                          |                                                        |
|------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>38114</b>                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>01/24/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HOLISTIC HEALTH CARE SERVICES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1544 ROUNDHOUSE CIRCLE<br/>SHAKOPEE, MN 55379</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ID<br>PREFIX<br>TAG                                                                           | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 0 470                                                                        | Continued From page 2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 0 470                                                                                         |                                                                                                                          |                                                        |
| 0 470<br>SS=F                                                                | <p>144G.41 Subdivision 1 Minimum requirements</p> <p>(11) develop and implement a staffing plan for determining its staffing level that:</p> <p>(i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility;</p> <p>(ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and</p> <p>(iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility;</p> <p>(12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be:</p> <p>(i) awake;</p> <p>(ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time;</p> <p>(iii) capable of communicating with residents;</p> <p>(iv) capable of providing or summoning the appropriate assistance; and</p> <p>(v) capable of following directions;</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on interview and record review, the licensee failed to ensure it employed a sufficient number of staff for 24/7 (24 hours per day, seven days per week) care. This had the potential to affect all residents and employees.</p> | 0 470                                                                                         |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                               |                                                                                                                          |                                                        |
|------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>38114</b>                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>01/24/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HOLISTIC HEALTH CARE SERVICES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1544 ROUNDHOUSE CIRCLE<br/>SHAKOPEE, MN 55379</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | ID<br>PREFIX<br>TAG                                                                           | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 0 470                                                                        | <p>Continued From page 3</p> <p>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).</p> <p>Findings include:</p> <p>During the entrance conference on January 23, 2023 at 10:40 a.m., registered nurse (RN)-A stated the licensee had two twelve hour shifts daily. The day shift ran from 8:00 a.m. to 8:00 p.m., and the night shift ran from 8:00 p.m. to 8:00 a.m.</p> <p>During an interview on January 23, 2023, at 1:45 p.m., RN-A stated the licensee employed three staff members. Unlicensed personnel (ULP)-B worked every night, ULP-C worked every day, and RN-A worked almost every day as well.</p> <p>The staff roster confirmed RN-A, ULP-B, and ULP-C were the only three staff employed by the licensee.</p> <p>The licensee failed to provide a policy regarding staffing.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) Days</p> | 0 470                                                                                         |                                                                                                                          |                                                        |
| 0 480<br>SS=F                                                                | <p>144G.41 Subd 1 (13) (i) (B) Minimum requirements</p> <p>(13) offer to provide or make available at least the</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 0 480                                                                                         |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                               |                                                                                                                          |                                                        |
|------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>38114</b>                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>01/24/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HOLISTIC HEALTH CARE SERVICES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1544 ROUNDHOUSE CIRCLE<br/>SHAKOPEE, MN 55379</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | ID<br>PREFIX<br>TAG                                                                           | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 0 480                                                                        | Continued From page 4<br><br>following services to residents:<br>(B) food must be prepared and served according<br>to the Minnesota Food Code, Minnesota Rules,<br>chapter 4626; and<br><br>This MN Requirement is not met as evidenced<br>by:<br>Based on observation, interview and record<br>review, the licensee failed to ensure food was<br>prepared and served according to the Minnesota<br>Food Code.<br><br>This practice resulted in a level two violation (a<br>violation that did not harm a resident's health or<br>safety but had the potential to have harmed a<br>resident's health or safety) and was issued at a<br>widespread scope (when problems are pervasive<br>or represent a systemic failure that has affected<br>or has the potential to affect a large portion or all<br>the residents).<br><br>The findings include:<br><br>Please refer to the included document titled, Food<br>and Beverage Establishment Inspection Report<br>dated January 23, 2023, for the specific<br>Minnesota Food Code deficiencies.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one<br>(21) days | 0 480                                                                                         |                                                                                                                          |                                                        |
| 0 490<br>SS=F                                                                | 144G.41 Subd 1 (13) (ii)-(vii) Minimum<br>requirements<br><br>(iv) upon the request of the resident, provide<br>direct or reasonable assistance with arranging for<br>transportation to medical and social services<br>appointments, shopping, and other recreation,<br>and provide the name of or other identifying                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 0 490                                                                                         |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                               |                                                                                                                          |                                                        |
|------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>38114</b>                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>01/24/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HOLISTIC HEALTH CARE SERVICES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1544 ROUNDHOUSE CIRCLE<br/>SHAKOPEE, MN 55379</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ID<br>PREFIX<br>TAG                                                                           | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 0 490                                                                        | <p>Continued From page 5</p> <p>information about the persons responsible for providing this assistance;<br/>(v) upon the request of the resident, provide reasonable assistance with accessing community resources and social services available in the community, and provide the name of or other identifying information about persons responsible for providing this assistance;<br/>(vi) provide culturally sensitive programs; and<br/>(vii) have a daily program of social and recreational activities that are based upon individual and group interests, physical, mental, and psychosocial needs, and that creates opportunities for active participation in the community at large; and</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on interview and record review, the licensee failed to provide culturally sensitive programs. This had the potential to affect all residents.</p> <p>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).</p> <p>Findings include:</p> <p>During the entrance conference on January 23, 2023, registered nurse (RN)-A stated the licensee did not provide culturally sensitive programs, but they could if needed.</p> <p>The licensee-provided policy titled Minimum</p> | 0 490                                                                                         |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                               |                                                                                                                          |                                                        |
|------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>38114</b>                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>01/24/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HOLISTIC HEALTH CARE SERVICES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1544 ROUNDHOUSE CIRCLE<br/>SHAKOPEE, MN 55379</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ID<br>PREFIX<br>TAG                                                                           | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 0 490                                                                        | Continued From page 6<br><br>Assisted Living Facility Requirements, undated,<br>indicated the licensee would provide culturally<br>sensitive programs.<br><br>TIME PERIOD FOR CORRECTION: Twenty-One<br>(21) Days                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 0 490                                                                                         |                                                                                                                          |                                                        |
| 0 550<br>SS=C                                                                | 144G.41 Subd. 7 Resident grievances; reporting<br>maltreatment<br><br>All facilities must post in a conspicuous place<br>information about the facilities' grievance<br>procedure, and the name, telephone number, and<br>email contact information for the individuals who<br>are responsible for handling resident grievances.<br>The notice must also have the contact<br>information for the Office of Ombudsman for<br>Long-Term Care and the Office of Ombudsman<br>for Mental Health and Developmental Disabilities<br>and must have information for reporting<br>suspected maltreatment to the Minnesota Adult<br>Abuse Reporting Center. The notice must also<br>state that if an individual has a complaint about<br>the facility or person providing services, the<br>individual may contact the Office of Health Facility<br>Complaints at the Minnesota Department of<br>Health.<br><br>This MN Requirement is not met as evidenced<br>by:<br>Based on observation and interview the licensee<br>failed to post information about the licensee's<br>grievance procedure, as well as the name,<br>telephone number, and email contact information<br>for the staff responsible for handling resident<br>grievances. This had the potential to affect all<br>residents. | 0 550                                                                                         |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                               |                                                                                                                          |                                                        |
|------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>38114</b>                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>01/24/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HOLISTIC HEALTH CARE SERVICES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1544 ROUNDHOUSE CIRCLE<br/>SHAKOPEE, MN 55379</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ID<br>PREFIX<br>TAG                                                                           | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 0 550                                                                        | Continued From page 7<br><br>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 of the residents).<br><br>The findings include:<br><br>During observation on January 23, 2023, the surveyor observed the licensee did not post information about the licensee's grievance procedure, as well as the name, telephone number, and email contact information for the staff responsible for handling resident grievances in a conspicuous place.<br><br>During the exit interview on January 24, 2023, at 12:10 p.m., registered nurse (RN)-A stated the licensee provided a copy to the residents but did not know it needed to be posted.<br><br>The licensee failed to provide a policy addressing the posting requirements in accordance with Minnesota (MN) Statute 144G.<br><br>TIME PERIOD FOR CORRECTION: Twenty-One (21) Days | 0 550                                                                                         |                                                                                                                          |                                                        |
| 0 570<br>SS=C                                                                | 144G.42 Subdivision 1 Display of license<br><br>The original current license must be displayed at the main entrance of each assisted living facility. The facility must provide a copy of the license to any person who requests it.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 0 570                                                                                         |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                               |                                                                                                                          |                                                        |
|------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>38114</b>                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>01/24/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HOLISTIC HEALTH CARE SERVICES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1544 ROUNDHOUSE CIRCLE<br/>SHAKOPEE, MN 55379</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | ID<br>PREFIX<br>TAG                                                                           | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 0 570                                                                        | Continued From page 8<br><br>This MN Requirement is not met as evidenced<br>by:<br>Based on observation and record review, the<br>licensee failed to display the original license at<br>the main entrance of the facility.<br><br>This practice resulted in a level one violation (a<br>violation that has no potential to cause more than<br>a minimal impact on the resident and does not<br>affect health or safety) and was issued at a<br>widespread scope (when problems are pervasive<br>or represent a systemic failure that has affected<br>or has the potential to affect a large portion or all<br>the residents).<br><br>Findings include:<br><br>During an observation on January 23, 2023 at<br>12:37 p.m., the licensee did not have the original<br>current license displayed at the main entrance of<br>the facility.<br><br>The licensee-provided policy titled Display of<br>License, undated, indicated the license would<br>display the current license in a prominent space<br>within the main entryway.<br><br>TIME PERIOD FOR CORRECTION: Twenty-One<br>(21) Days | 0 570                                                                                         |                                                                                                                          |                                                        |
| 0 630<br>SS=D                                                                | 144G.42 Subd. 6 (b) Compliance with<br>requirements for reporting ma<br><br>(b) The facility must develop and implement an<br>individual abuse prevention plan for each<br>vulnerable adult. The plan shall contain an<br>individualized review or assessment of the<br>person's susceptibility to abuse by another                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 0 630                                                                                         |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                               |                                                                                                                          |                                                        |
|------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>38114</b>                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>01/24/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HOLISTIC HEALTH CARE SERVICES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1544 ROUNDHOUSE CIRCLE<br/>SHAKOPEE, MN 55379</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ID<br>PREFIX<br>TAG                                                                           | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 0 630                                                                        | <p>Continued From page 9</p> <p>individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse.</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on interview and record review, the licensee failed to address the risk for self-abuse in the individualized abuse prevention plan (IAPP) for one of one residents (R1) with records reviewed.</p> <p>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).</p> <p>Findings include:</p> <p>R1 admitted to the licensee December 20, 2022. R1's diagnoses included hypertension, paranoid personality disorder, and depression. R1's service agreement, dated December 20, 2022, indicated R1 received services including behavior management and safety checks daily.</p> <p>R1's IAPP dated December 29, 2022 failed to address R1's risk for self-abuse.</p> <p>During the exit conference on January 24, 2023 at 12:10 p.m., registered nurse (RN)-A acknowledged this requirement was not met and</p> | 0 630                                                                                         |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                               |                                                                                                                          |                                                        |
|------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>38114</b>                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>01/24/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HOLISTIC HEALTH CARE SERVICES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1544 ROUNDHOUSE CIRCLE<br/>SHAKOPEE, MN 55379</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ID<br>PREFIX<br>TAG                                                                           | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 0 630                                                                        | Continued From page 10<br><br>stated she could add it to the assessment.<br><br>The licensee-provided policy titled Abuse Prevention, undated, indicated the licensee would assess residents to determine vulnerability to abuse or neglect and develop a specific plan to minimize the risk of abuse to the resident. This policy indicated abuse included self-abuse.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) Days                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 0 630                                                                                         |                                                                                                                          |                                                        |
| 0 680<br>SS=I                                                                | 144G.42 Subd. 10 Disaster planning and emergency preparedness<br><br>(a) The facility must meet the following requirements:<br>(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;<br>(2) post an emergency disaster plan prominently;<br>(3) provide building emergency exit diagrams to all residents;<br>(4) post emergency exit diagrams on each floor; and<br>(5) have a written policy and procedure regarding missing residents.<br>(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. | 0 680                                                                                         |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                               |                                                                                                                          |                                                        |
|------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>38114</b>                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>01/24/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HOLISTIC HEALTH CARE SERVICES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1544 ROUNDHOUSE CIRCLE<br/>SHAKOPEE, MN 55379</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ID<br>PREFIX<br>TAG                                                                           | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 0 680                                                                        | <p>Continued From page 11</p> <p>(c) The facility must meet any additional requirements adopted in rule.</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on interview and record review, the licensee failed to ensure its emergency preparedness plan included all required content. This had the potential to affect all residents, staff, and visitors.</p> <p>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).</p> <p>The findings include:</p> <p>The licensee's emergency program (EP) failed to include:</p> <ul style="list-style-type: none"> <li>-how the licensee would coordinate with other health care facilities and the community during emergency or disaster</li> <li>-arrangements/contracts to re-establish utility services</li> <li>- a process for cooperation with local, tribal, regional, State, and Federal EP to maintain integrated response</li> <li>-a written communication plan including all required content</li> <li>-policies/procedures related to:</li> <li>-minimum food, water, and pharmaceutical supplies</li> <li>-alternate sources of energy</li> <li>-missing residents</li> </ul> | 0 680                                                                                         |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                               |                                                                                                                          |                                                        |
|------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>38114</b>                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>01/24/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HOLISTIC HEALTH CARE SERVICES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1544 ROUNDHOUSE CIRCLE<br/>SHAKOPEE, MN 55379</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ID<br>PREFIX<br>TAG                                                                           | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 0 680                                                                        | <p>Continued From page 12</p> <ul style="list-style-type: none"> <li>-system to track the location of on-duty staff and sheltered residents</li> <li>-how the licensee will provide means to shelter in place</li> <li>-system of medical documentation that preserves resident information, protects confidentiality, and secures/ maintains availability of records</li> <li>-use of volunteers and other emergency staffing strategies, including the process/role for integration</li> <li>-for providing care and treatment at alternate care sites under 1135 waiver</li> <li>-a written training and testing program including all requirements for drills and exercises</li> </ul> <p>The licensee also failed to post the emergency disaster plan prominently.</p> <p>The licensee lacked evidence of making emergency and disaster training available to residents.</p> <p>During an interview on January 24, 2023 at 9:31 a.m., registered nurse (RN)-A stated to coordinate with other facilities, the licensee would call 911. RN-A stated the licensee did not include a process for cooperation with local, tribal, regional, State, and Federal EP, but it could look into it in the future. Regarding a communication plan, RN-A stated she can send out messages to staff using their electronic charting system.</p> <p>The licensee-provided policy titled Emergency Preparedness, undated, indicated the licensee would have an identified plan in place. This policy indicated the emergency disaster plan would be posted on each floor, and residents would be offered training.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-One</p> | 0 680                                                                                         |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                               |                                                                                                                          |                                                        |
|------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>38114</b>                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>01/24/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HOLISTIC HEALTH CARE SERVICES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1544 ROUNDHOUSE CIRCLE<br/>SHAKOPEE, MN 55379</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ID<br>PREFIX<br>TAG                                                                           | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 0 680                                                                        | Continued From page 13<br><br>(21) Days                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 0 680                                                                                         |                                                                                                                          |                                                        |
| 0 780<br>SS=F                                                                | <p>144G.45 Subd. 2 (a) (1) Fire protection and physical environment</p> <p>(a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and:</p> <p>(1) for dwellings or sleeping units, as defined in the State Fire Code:</p> <p>(i) provide smoke alarms in each room used for sleeping purposes;</p> <p>(ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms;</p> <p>(iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics;</p> <p>(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</p> <p>(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;</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on observation and interview, the licensee failed to provide smoke alarms that are interconnected so that 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.</p> | 0 780                                                                                         |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                               |                                                                                                                          |                                                        |
|------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>38114</b>                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>01/24/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HOLISTIC HEALTH CARE SERVICES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1544 ROUNDHOUSE CIRCLE<br/>SHAKOPEE, MN 55379</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ID<br>PREFIX<br>TAG                                                                           | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 0 780                                                                        | Continued From page 14<br><br>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). Findings include:<br><br>On a facility tour with the manager, unlicensed personnel (ULP)-B On January 24, 2023, at approximately 10:00 a.m., it was observed that the sleeping rooms that were equipped with smoke alarms were not interconnected with the smoke alarms the immediately outside of the sleeping room so that actuation of one alarm would cause all alarms to operate. This deficient condition was visually verified by ULP-B accompanying the tour.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days. | 0 780                                                                                         |                                                                                                                          |                                                        |
| 0 790<br>SS=F                                                                | 144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment<br><br>(2) install and maintain portable fire extinguishers in accordance with the State Fire Code;<br><br>(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                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 0 790                                                                                         |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                               |                                                                                                                          |                                                        |
|------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>38114</b>                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>01/24/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HOLISTIC HEALTH CARE SERVICES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1544 ROUNDHOUSE CIRCLE<br/>SHAKOPEE, MN 55379</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | ID<br>PREFIX<br>TAG                                                                           | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 0 790                                                                        | Continued From page 15<br><br>Code; and<br><br>This MN Requirement is not met as evidenced<br>by:<br>Based on observation and interview, the licensee<br>failed to maintain fire extinguishers in accordance<br>with MN State Fire Code as required by MN<br>Statute 144G.45 Subd.2 (a)(2). This had the<br>potential to affect all current residents, staff and<br>visitors.<br><br>This practice resulted in a level two violation (a<br>violation that did not harm a resident's health or<br>safety but had the potential to have harmed a<br>resident's health or safety, but was not likely to<br>cause serious injury, impairment, or death), and<br>was issued at a widespread scope (when<br>problems are pervasive or represent a systemic<br>failure that has affected or has potential to affect<br>a large portion or all of the residents).<br>Findings include:<br><br>On January 24, 2023, at approximately 10:00<br>a.m., survey staff toured the facility with the<br>manager, unlicensed personnel (ULP)-B. During<br>the facility tour, survey staff observed that<br>portable fire extinguishers were not provided with<br>tags or labels from certified service personnel<br>indicating that annual maintenance had been<br>performed. This deficient condition was visually<br>verified by ULP-B accompanying the tour.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one<br>(21) days | 0 790                                                                                         |                                                                                                                          |                                                        |
| 0 800<br>SS=F                                                                | 144G.45 Subd. 2 (a) (4) Fire protection and<br>physical environment                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 0 800                                                                                         |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                               |                                                                                                                          |                                                        |
|------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>38114</b>                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>01/24/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HOLISTIC HEALTH CARE SERVICES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1544 ROUNDHOUSE CIRCLE<br/>SHAKOPEE, MN 55379</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ID<br>PREFIX<br>TAG                                                                           | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 0 800                                                                        | <p>Continued From page 16</p> <p>(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.</p> <p>This MN Requirement is not met as evidenced by:<br/>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 ability to affect a limited number of staff and residents.</p> <p>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).</p> <p>Findings include:</p> <p>On January 24, 2023, at approximately 10:00 a.m., survey staff toured the facility with the manager, unlicensed personnel (ULP)-B. During the facility tour, survey staff observed following items:</p> <p>It was observed that the cabinet over the</p> | 0 800                                                                                         |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                               |                                                                                                                          |                                                        |
|------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>38114</b>                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>01/24/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HOLISTIC HEALTH CARE SERVICES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1544 ROUNDHOUSE CIRCLE<br/>SHAKOPEE, MN 55379</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | ID<br>PREFIX<br>TAG                                                                           | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 0 800                                                                        | Continued From page 17<br><br>bathroom sink on the lower level was loosely attached to the wall and an anchoring bolt was missing at one side of the cabinet.<br><br>It was observed that the upper-level deck was covered with snow and the metal gate was frozen shut from built-up snow and ice at the top of the exit stair on the deck. This deck door was identified as an exit on the evacuation plans posted in the facility. This deficient condition was visually verified by ULP-B accompanying the tour.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days                                                                                                                                                                                                                                                                                                                                                                                   | 0 800                                                                                         |                                                                                                                          |                                                        |
| 0 810<br>SS=F                                                                | 144G.45 Subd. 2 (b)-(f) Fire protection and physical environment<br><br>(b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to:<br>(1) location and number of resident sleeping rooms;<br>(2) employee actions to be taken in the event of a fire or similar emergency;<br>(3) fire protection procedures necessary for residents; and<br>(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.<br>(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.<br>(d) Fire safety and evacuation plans shall be readily available at all times within the facility.<br>(e) Residents who are capable of assisting in | 0 810                                                                                         |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                               |                                                                                                                          |                                                        |
|------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>38114</b>                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>01/24/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HOLISTIC HEALTH CARE SERVICES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1544 ROUNDHOUSE CIRCLE<br/>SHAKOPEE, MN 55379</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ID<br>PREFIX<br>TAG                                                                           | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 0 810                                                                        | <p>Continued From page 18</p> <p>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.</p> <p>(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.</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on observation, interview, and record review, the licensee failed to develop a fire safety and evacuation plan with required elements; failed to provide required employee training on fire safety and evacuation; failed to provide training to residents capable of assisting in their own evacuation and failed to conduct required evacuation drills. This had the potential to affect all staff, residents, and visitors.</p> <p>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).</p> <p>Findings include:</p> <p>An interview and record review of the available documentation were conducted on January 24, 2023, at approximately 10:00 a.m. with the</p> | 0 810                                                                                         |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                               |                                                                                                                          |                                                        |
|------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>38114</b>                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>01/24/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HOLISTIC HEALTH CARE SERVICES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1544 ROUNDHOUSE CIRCLE<br/>SHAKOPEE, MN 55379</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ID<br>PREFIX<br>TAG                                                                           | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 0 810                                                                        | <p>Continued From page 19</p> <p>Registered Nurse (RN)-A, manager/unlicensed personnel (ULP)-B on the fire safety and evacuation plan, fire safety and evacuation training for the facility, and fire safety and evacuation drills for the facility. Record review of the available documentation indicated that the fire safety and evacuation plan was not maintained.</p> <p>Review of the available Emergency Preparedness Plan binder indicated that the license did have an unedited copy of the Minnesota Long Term Care Preparedness Tool kits with some provisions for the fire safety requirement. During the interview, RN-A stated that she did not implement the Minnesota Long Term Care Preparedness Tool kits to the facility-specific requirement, and she was not aware of any provisions in the fire safety and evacuation plan for this requirement. RN-A and ULP- B verified that the fire safety and evacuation plan for the facility lacked these provisions.</p> <p>Record review of the Emergency Preparedness Plan provided by RN-A indicated that the plan did not have provisions for employee actions to be taken in the event of a fire or similar emergency, provisions for actions to be taken for residents who are capable of self-evacuation, and 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. During interview, RN-A, and ULP- B stated that the licensee did not have a policy or a fire safety and evacuation plan that included these items. Review of the Emergency Disaster Plan provided by RN-A indicated that all staff receives emergency and disaster training in orientation and annually, not twice per year after initial hire</p> | 0 810                                                                                         |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                               |                                                                                                                          |                                                        |
|------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>38114</b>                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>01/24/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HOLISTIC HEALTH CARE SERVICES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1544 ROUNDHOUSE CIRCLE<br/>SHAKOPEE, MN 55379</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ID<br>PREFIX<br>TAG                                                                           | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 0 810                                                                        | Continued From page 20<br><br>as required by statute. No additional training records were provided.<br><br>Record review of the available documentation did not indicate that the licensee provides annual training to residents who can assist in their own evacuation on the proper actions to take in the event of a fire including movement, evacuation, or relocation as required by statute.<br><br>Review of the Emergency Disaster Plan provided by RN-A indicated that fire drills or other emergency drills are to be conducted every 6 months, not every other month as required by statute. The policy also did not make reference to the minimum requirement of twice per year per shift. No documentation of conducted drills was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 810                                                                                         |                                                                                                                          |                                                        |
| 01460<br>SS=D                                                                | 144G.63 Subdivision 1 Orientation of staff and supervisors<br><br>All staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. The orientation may be incorporated into the training required under subdivision 5. The orientation need only be completed once for each staff person and is not transferable to another facility.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to complete orientation before                                                                                                                                                                               | 01460                                                                                         |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                               |                                                                                                                          |                                                        |
|------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>38114</b>                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>01/24/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HOLISTIC HEALTH CARE SERVICES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1544 ROUNDHOUSE CIRCLE<br/>SHAKOPEE, MN 55379</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ID<br>PREFIX<br>TAG                                                                           | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 01460                                                                        | Continued From page 21<br><br>providing services to residents for one of two staff members (registered nurse (RN)-A) with records reviewed.<br><br>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).<br><br>Findings include:<br><br>RN-A started working at the licensee August 23, 2022. RN-A's employee record lacked evidence of a completed orientation.<br><br>During the exit interview on January 24, 2023, at 12:10 p.m., RN-A stated if an orientation checklist was not in her file, it probably did not get completed.<br><br>The licensee-provided policy titled Staff Orientation & Education, undated, indicated all employees attended a general orientation including all required content upon hire and prior to providing services to residents.<br><br>TIME PERIOD FOR CORRECTION: Twenty-One (21) Days | 01460                                                                                         |                                                                                                                          |                                                        |
| 01610<br>SS=D                                                                | 144G.70 Subd. 2 (a-b) Initial reviews, assessments, and monitoring<br><br>(a) Residents who are not receiving any assisted living services shall not be required to undergo an                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 01610                                                                                         |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                               |                                                                                                                          |                                                        |
|------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>38114</b>                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>01/24/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HOLISTIC HEALTH CARE SERVICES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1544 ROUNDHOUSE CIRCLE<br/>SHAKOPEE, MN 55379</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ID<br>PREFIX<br>TAG                                                                           | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 01610                                                                        | <p>Continued From page 22</p> <p>initial nursing assessment.</p> <p>(b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan 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. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery.</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on interview and record review, the licensee failed to complete a physical and cognitive assessment on or before move-in for one of one residents (R1) with records reviewed.</p> <p>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).</p> <p>Findings include:</p> <p>R1 admitted to the licensee December 20, 2022. R1's diagnoses included hypertension, paranoid personality disorder, and depression. R1's service agreement, dated December 20, 2022, indicated R1 received services including behavior</p> | 01610                                                                                         |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                           |                                                                                                                          |                          |                                                        |
|------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>38114</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>01/24/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HOLISTIC HEALTH CARE SERVICES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                           | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1544 ROUNDHOUSE CIRCLE<br/>SHAKOPEE, MN 55379</b>                            |                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ID<br>PREFIX<br>TAG                                                       | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                        |
| 01610                                                                        | <p>Continued From page 23</p> <p>management and safety checks daily. Registered nurse (RN)-A completed R1's assessment on December 21, 2022.</p> <p>R1's record lacked a pre-admission assessment prior to execution of the assisted living contract and move in.</p> <p>During the exit conference on January 24, 2023, at 12:10 p.m., RN-A stated she completed R1's assessment the day after he admitted because the licensee did not know when exactly he would be arriving at the licensee.</p> <p>The licensee-provided policy titled Assessment - Comprehensive Services, undated, indicated the RN would complete an initial assessment within five days of the initiation of services. This assessment did not address the requirement to complete an assessment prior to move-in.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) Days</p> | 01610                                                                     |                                                                                                                          |                          |                                                        |

Type: Full  
Date: 01/23/23  
Time: 11:00:00  
Report: 8041231015

## Food and Beverage Establishment Inspection Report

Page 1

**Location:**

Holistic Health Care Services  
1544 Roundhouse Circle  
Shakopee, MN55379  
Scott County, 70

**Establishment Info:**

ID #: N041057  
Risk:  
Announced Inspection: No

**License Categories:**

Expires on: 12/31/23

**Operator:**

Phone #:  
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 at the specific request of the regulatory authority.

EMPLOYEE ILLNESS LOG COULD NOT BE FOUND. EXCLUSION AND LOGGING REQUIREMENTS REVIEWED. MDH EMPLOYEE ILLNESS LOG FORM SENT TO ESTABLISHMENT.

*Comply By: 01/23/23*

### 3-300B Protection from Contamination: cross-contamination, eggs

3-302.11A(1)

**\*\* Priority 1 \*\***

MN Rule 4626.0235A(1) Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.

UNPASTEURIZED SHELL EGGS STORED ON TOP SHELF IN REFRIGERATOR ABOVE READY-TO-EAT FOODS. SHELL EGGS WERE MOVED TO LOWER SHELF DURING INSPECTION. CORRECT STORAGE ORDER TO PREVENT CROSS CONTAMINATION REVIEWED.

*Comply By: 01/23/23*

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

Inspection was completed with the Administrator, Ridwan Mohamed. Nicole Myslicki was the lead RN with HRD present. Facility had two residents on site at time of inspection.

This establishment has a residential kitchen and food is prepared for same day service only. The kitchen

Type: Full  
Date: 01/23/23  
Time: 11:00:00  
Report: 8041231015  
Holistic Health Care Services

# Food and Beverage Establishment Inspection Report

Page 2

has wood cabinets with a hollow base and a solid surface counter top, a popcorn ceiling and wood flooring. All found to be in good condition.

A two basin sink is located in the kitchen with one basin designed for handwashing. Frigidaire (residential) dish machine has a sanitizing cycle option. The dish machine was tested by the operator and had a utensil surface temperature of 165 Deg. F.

Discussed the following:

- Employee illness policy and log
- Handwashing
- Glove-use and bare hand contact
- Proper cold holding and food storage
- Date marking
- Vomit clean up procedures
- Restrictions concerning serving a highly susceptible population

**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 8041231015 of 01/23/23.

Certified Food Protection Manager Ridwan Mohamed

Certification Number: fm108139 Expires:    /    /   

**Inspection report reviewed with person in charge and emailed.**

Signed: \_\_\_\_\_

Ridwan Mohamed  
Administrator

Signed: \_\_\_\_\_



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