Electronically Delivered

September 25, 2023

Licensee
Live Well MN Home Health Care
7780 Long Lake Road
Mounds View, MN  55112

RE:  Project Number(s) SL38979015

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.

The Minnesota Department of Health completed an initial survey on September 14, 2023, for the purpose assessing compliance with state licensing statutes. At the time of the survey, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G.

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

**STATE CORRECTION ORDERS**
The enclosed State Form documents the state correction orders. The Department of Health documents state 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 survey of your facility.

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

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.

- Identify how the area(s) of noncompliance was corrected for all of the provider's 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 correction order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

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).

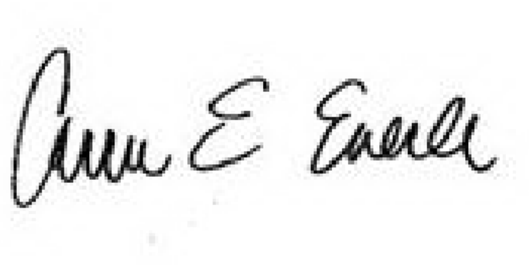
Please address your cover letter for reconsideration requests to:

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 the letter and/or state form with your organization's Governing Body.

If you have any questions, please contact me.

Sincerely,



Carrie Euerle, Supervisor
State Rapid Response Team
Email: carrie.euerle@state.mn.us
Telephone: 651-242-8846 Fax: 651-215-6894

HHH

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 38979 | A. BUILDING: _____ B. WING _____ | 09/14/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LIVE WELL MN HOME HEALTH CARE | 7780 LONG LAKE ROAD MOUNDS VIEW, MN 55112 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
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| 0 000 | Initial Comments<br><br>******ATTENTION******<br><br>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDERS<br><br>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey.<br><br>Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance.<br><br>INITIAL COMMENTS:<br>SL38979015-0<br><br>On September 11, 2023, through September 14, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were four active residents receiving services under the provider's provisional Assisted Living license. | 0 000 | Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction.<br><br>PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.<br><br>The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3. | |
| 0 470 SS=F | 144G.41 Subdivision 1 Minimum requirements<br><br>(11) develop and implement a staffing plan for determining its staffing level that: | 0 470 | | |

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| 0 470 | Continued From page 1<br>(i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility;<br>(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<br>(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;<br>(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:<br>(i) awake;<br>(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;<br>(iii) capable of communicating with residents;<br>(iv) capable of providing or summoning the appropriate assistance; and<br>(v) capable of following directions;<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to develop and implement a written staffing plan that included an evaluation completed by a registered nurse at least twice a year. This had the potential to affect all 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 | 0 470 | | |

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| 0 470 | Continued From page 2<br><br>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><br>The findings include:<br><br>The licensee held a provisional assisted living license. The facility was licensed for a capacity of five residents and had a current census of four residents.<br><br>On September 11, 2023, at 10:30 a.m., during the entrance conference, the surveyor inquired if the licensee developed and implemented a staffing plan that was evaluated twice per year. Licensed assisted living director in residence (LALDIR)-B stated, "yes."<br><br>The surveyor requested the licensee's staffing plan.<br><br>The licensee's undated staffing plan indicated two direct care staff were scheduled to work each shift.<br><br>The staffing plan lacked the following required content:<br>-an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility;<br>-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<br>-ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster | 0 470 | | |

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| 0 470 | Continued From page 3<br><br>situations affecting staff or residents in the facility;<br>-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.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 0 470 | | |
| 0 480 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:<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: | 0 480 | | |

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| 0 480 | Continued From page 4<br>Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated September 12, 2023, for the specific Minnesota Food Code deficiencies.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 480 | | |
| 0 485 SS=F | 144G.41 Subdivision 1. (13)(i)(A)and(C) Minimum Requirements<br><br>(13) offer to provide or make available at least the following services to residents:<br>(i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply:<br>(A) menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes; and<br>(C) the facility cannot require a resident to include and pay for meals in their contract;<br>(ii) weekly housekeeping;<br>(iii) weekly laundry service;<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed ensure to offer at least three nutritious meals daily, according to the recommended dietary allowances in the United Stated Department of Agriculture (USDA) guidelines. This had the potential to affect all | 0 485 | | |

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| 0 485 | Continued From page 5<br>residents who received services.<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><br>The findings include:<br><br>On September 11, 2023, at 12:10 p.m., unlicensed personnel (ULP)-D was observed making a hamburger and toast for a resident. The surveyor did not observe the scheduled meal being prepared and the residents in the facility at the time were served lunch they requested.<br><br>The posted weekly menu contained the following meals:<br><br>Monday:<br>Breakfast: Omelettes and oranges<br>Lunch: Country fried beef steak<br>Dinner: Any meat burger/fries<br><br>Tuesday:<br>Breakfast: pancake, banana, yogurt<br>Lunch: chicken tikki marsala<br>Dinner: bean and cheese burritos<br><br>Wednesday:<br>Breakfast: Steak and eggs breakfast bowl<br>Lunch: spaghetti and meatballs<br>Dinner: chicken fried rice<br><br>Thursday: | 0 485 | | |

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| 0 485 | Continued From page 6<br><br>Breakfast: cereal and yogurt<br>Lunch: beef and bean tacos<br>Dinner: beef stir veggies<br><br>Friday:<br>Breakfast: blueberry pancakes and oranges<br>Lunch: any meat burgers and fries<br>Dinner: Asian chicken and broccoli<br><br>Saturday:<br>Breakfast: white or wheat toast, orange/banana<br>Lunch: roasted beef<br>Dinner: spaghetti and meatballs<br><br>Sunday:<br>Breakfast: biscuit sausage egg or cheese<br>Lunch: chicken stir veggies<br>Dinner: pizza (cheese or chicken)<br><br>The bottom of the menu indicated meal sides included white rice, brown rice, angel hair, mashed potato, mac and cheese, Caesar salad, garden salad, or french fries/chips. Dessert options were mixed fruits, cookies, or ice cream.<br><br>On September 11, 2023, at 12:35 p.m., housing manager (HM)-C stated they make most meals to order based off what the resident requests. HM-C stated the current residents prefer burgers or eggs and toast for most meals and they honor those requests. HM-C stated fruit is available and many of the residents like grapes, oranges, and grapefruit. HM-C stated they have their menu but many of the residents request different foods and they try to make what the residents ask for.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 485 | | |

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| 0 580 SS=F | 144G.42 Subd. 2 Quality management<br><br>The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to implement and maintain a quality management program (QMP) appropriate to the size of the facility and relevant to the type of services provided. 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) 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>On September 11, 2023, at 10:30 a.m., during the entrance conference, the surveyor inquired if the licensee had a quality management program. | 0 580 | | |

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| 0 580 | Continued From page 8<br><br>Licensed assisted living director in residence (LALDIR)-B stated, "yes."<br><br>On September 12, 2023, at 12:10 p.m., the surveyor requested documentation of the quality management meetings.<br><br>On September 14, 2023, at 4:40 p.m., licensed assisted living director in residence (LALDIR)-B stated the facility held quarterly quality management meetings and he would send minutes when they access the computer they are stored on.<br><br>On September 14, 2023, at 5:09 p.m., the surveyor again requested documentation of the quality management meetings.<br><br>No quality management meeting documentation was provided.<br><br>No further information provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 580 | | |
| 0 630 SS=F | 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 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 | 0 630 | | |

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| 0 630 | Continued From page 9<br><br>abuse prevention plan, abuse includes self-abuse.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for two of two residents (R1, R2).<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><br>The findings include:<br><br>R1<br>R1 was admitted on November 1, 2022.<br><br>R1's diagnoses included chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), and degenerative arthritis.<br><br>R1's undated, unsigned, service plan listed 14 services including assistance with bathing, dressing, grooming, toileting, transfers, and meals with an effective date of September 11, 2023.<br><br>R1's most recent IAPP, dated September 5, 2023, lacked the following required content:<br>-an individualized review or assessment of the person's susceptibility to abuse by another | 0 630 | | |

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| 0 630 | Continued From page 10<br><br>individual, including other vulnerable adults;<br>-the person's risk of abusing other vulnerable adults; and<br>-statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults.<br><br>R2<br>R2 was admitted on February 27, 2023.<br><br>R2's diagnoses included chronic obstructive pulmonary disease (COPD), epilepsy, and depression.<br><br>R2's undated, unsigned, service plan listed five services including assistance with ambulation, grooming, bathing, and medication set up, with an effective date of September 11, 2023.<br><br>R2's most recent IAPP, dated September 5, 2023, lacked the following required content:<br>-an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults;<br>-the person's risk of abusing other vulnerable adults; and<br>-statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults.<br><br>On September 14, 2023, at 4:40 p.m., licensed assisted living director in residence (LALDIR)-B confirmed the IAPPs were missing some of the required content.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 0 630 | | |

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| | 38979 | A. BUILDING: _____ B. WING _____ | 09/14/2023 |

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|---|---|
| LIVE WELL MN HOME HEALTH CARE | 7780 LONG LAKE ROAD MOUNDS VIEW, MN 55112 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
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| 0 650 | Continued From page 11 | 0 650 | | |
| 0 650 SS=E | 144G.42 Subd. 8 Employee records<br><br>(a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information:<br>(1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules;<br>(2) records of orientation, required annual training and infection control training, and competency evaluations;<br>(3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision;<br>(4) documentation of annual performance reviews that identify areas of improvement needed and training needs;<br>(5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and<br>(6) documentation of the background study as required under section 144.057.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure the employee record contained the required content for two of two unlicensed personnel, (ULP-D and housing manager (HM)-C).<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 | 0 650 | | |

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| 0 650 | Continued From page 12<br><br>cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).<br><br>The findings include:<br><br>ULP-D<br>ULP-D was hired November 1, 2022, to provide direct care and services to the licensee's residents.<br><br>ULP-D's employee record lacked evidence of records of orientation, including competency testing in the required areas for unlicensed personnel.<br><br>HM-C<br>HM-C was hired on November 1, 2022, to provide direct care and services to the licensee's residents and oversee operations at the facility.<br><br>HM-C's employee record lacked evidence of records of orientation, including competency testing in the required areas for unlicensed personnel.<br><br>On September 14, 2023, at 4:40 p.m., licensed assisted living director in residence (LALDIR)-B stated all unlicensed personnel (ULP) completed training with the registered nurse (RN) and that staff would have to do a return demonstration on skills for the RN to determine competency. LALDIR-B stated both employees should have documentation of this as it was completed.<br><br>On September 14, 2023, at 5:09 p.m., the surveyor requested documentation of training, | 0 650 | | |

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| 0 650 | Continued From page 13<br><br>however no additional documentation was provided.<br><br>The licensee's Competency Training Evaluations policy, dated October 10, 2022, indicated a registered nurse (or other licensed health professional where appropriate) would determine what nursing services may be delegated to properly trained and competency tested unlicensed personnel.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 650 | | |
| 0 680 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 | 0 680 | | |

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| 0 680 | Continued From page 14<br><br>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 requirements adopted in rule.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to develop and post a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all residents, staff, and visitors of the facility.<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 of the residents).<br><br>The findings include:<br><br>The licensee's emergency preparedness plan did not include the development of policies/procedures based on risk assessment, and additional policies individualized to the facility for:<br>- procedure for tracking staff and residents<br>- subsistence needs for staff and residents during an emergency to include (food, water, medical supplies, pharmacy supplies, sewer and waste disposal, emergency lighting, fire detection, extinguishing and alarm systems);<br>- evacuation plan which included staff responsibilities during an evacuation and transporting services for residents being evacuated | 0 680 | | |

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| 0 680 | Continued From page 15<br><br>- shelter in place (not specific to meet the needs of the residents and staff);<br>- development of arrangements with other facilities and providers to receive residents if needed;<br>-evidence of exercises to test the emergency plan at least twice per year; and<br><br>A communication plan that included:<br>- a method of sharing information and medical documentation for residents<br>- alternate ways of communication; and<br>- a method of sharing information from the EPP with residents and their families<br><br>On September 11, 2023, at 11:30 a.m., licensed assisted living director in residence (LALDIR)-B confirmed the plan was missing some of the required content. LALDIR-B stated the facility had not yet done any testing of the emergency plan aside from fire drills.<br><br>The licensee's Emergency Preparedness policy, dated August 1, 2021, indicated the facility would have an identified plan in place to assure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupts services.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-One (21) days | 0 680 | | |
| 0 810 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 | 0 810 | | |

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| 0 810 | Continued From page 16<br>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 training shall be made available to residents at least once per year.<br>(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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on record review and interview, the licensee failed to develop fire safety and evacuation plans with the required elements; failed to provide training to residents capable of assisting in their own evacuation; and failed to complete the required employee evacuation drills. | 0 810 | | |

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| 0 810 | Continued From page 17<br><br>This had the potential to affect all staff, residents, 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) 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>On September 12, 2023, at approximately 2:30 p.m., a record review and interview with the housing manager (HM)-C were completed by survey staff.<br><br>1. Record review of the available documentation indicated that the licensee had not developed plans with complete employee actions on how to move or evacuate residents in the event of a fire or similar emergency from this facility location.<br><br>2. Record review of the available documentation indicated that the licensee had not developed plans with fire protection procedures necessary for residents from this facility location.<br><br>3. Record review of the available documentation indicated that the licensee had not developed plans with procedures for resident relocation during a fire or similar emergency.<br><br>4. Record review of the available documentation indicated that the licensee did not have a policy for annual resident training on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. Additionally, no training | 0 810 | | |

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| 0 810 | Continued From page 18<br><br>records were provided to support that resident training had been completed.<br><br>5. Record review of the available documentation indicated that the facility had the correct evacuation drill frequency in policy, but only one evacuation drill record listed the names of the employees who participated. Documentation was not provided to support that the employee evacuation drill frequency requirement of twice per year per shift with at least one evacuation drill every other month had been met.<br><br>On September 12, 2023, at approximately 2:55 p.m., HM-C verified these deficient conditions.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 810 | | |
| 0 970 SS=C | 144G.50 Subd. 5 Waivers of liability prohibited<br><br>The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the facility's liability for health, safety, or personal property of a resident. This had the potential to affect all residents. | 0 970 | | |

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| 0 970 | Continued From page 19<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>R1<br>R1 was admitted on November 1, 2022.<br><br>R1's record contained an assisted living contract dated November 1, 2022.<br><br>R2<br>R2 was admitted on February 27, 2023.<br><br>R2's record contained an assisted living contract dated February 27, 2023.<br><br>The Assisted Living Contract signed by both R1 and R2 contained the following language:<br><br>Miscellaneous Provisions 1. Insurance Liability and Release. The resident shall maintain at all times his or her own health, personal property, liability, automobile (if applicable), and other insurance coverage and shall provide evidence of same by copies of binders or policies provided to Live Well MN Home Health Care upon request. The resident agrees that Live Well MN Home Health Care will not be liable to the resident for any personal injury or property damage (including, without limitation, damage to, or loss or theft of, automobiles or personal property of resident) suffered by the resident or the resident's | 0 970 | | |

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| 0 970 | Continued From page 20<br><br>agents, guests or invitees, unless and to the extent that the injury or damage is caused by the negligence of Live Well MN Home Health Care or its employees or agents. The resident hereby releases Live Well MN Home Health Care from any liability for any personal injury or property damage suffered by the resident or the resident's agents, guests, or invitees, unless caused by the negligence of Live Well MN Home Health Care or its employees or agents.<br><br>Indemnification: Live Well MN Home Health Care shall not be liable for any damage or injury to the resident, or any other person, or to any property, occurring on the premises, or any part thereof, or in common areas thereof, and the resident agrees to hold Live Well MN Home Health Care harmless from any claims or damages unless caused solely by the negligence of Live Well MN Home Health Care. It is recommended that renter's insurance be purchased at the resident's expense. Nothing contained herein is intended to create a waiver of facility liability for the health and safety or personal property of a resident.<br><br>Liability: The resident agrees to be liable and responsible for all obligations herein referenced, monetary and otherwise, of the resident and where this Contract has been executed by a party designated below. Or where a separate Responsible Party Agreement has been executed by a third party, said third party and the resident shall jointly and severally liable and responsible for all obligations, monetary and otherwise, of the resident herein referenced.<br><br>On September 14, 2023, at 4:40 p.m., licensed assisted living director in residence (LALDIR)-B confirmed the assisted living contract contained language that waived the facility's liability for | 0 970 | | |

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| 0 970 | Continued From page 21<br>health, safety, or personal property of a resident.<br><br>No further information provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 970 | | |
| 01610 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 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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed a pre-admission assessment of the physical and cognitive needs of the prospective resident before the initiation of services for one of two residents (R1).<br><br>This practice resulted in a level two violation (a | 01610 | | |

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| 01610 | Continued From page 22<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, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).<br><br>The findings include:<br><br>R1 was admitted on November 1, 2022.<br><br>R1's diagnoses included chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), and degenerative arthritis.<br><br>R1's undated, unsigned, service plan listed 14 services including assistance with bathing, dressing, grooming, toileting, transfers, and meals, with an effective date of September 11, 2023.<br><br>Page four of R1'S service plan included a section for for the resident or their representative and a facility representative to sign, but all sections were blank.<br><br>Progress notes indicated R1 moved into the facility on November 1, 2022, and began receiving services on that date.<br><br>R1's admission assessment was requested and an assessment dated November 3, 2022, was provided.<br><br>On September 14, 2023, at 4:40 p.m., licensed assisted living director in residence (LALDIR)-B stated he thought a preadmission assessment was completed but was not able to access it in | 01610 | | |

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| 01610 | Continued From page 23<br>the electronic medical record and would have to ask the nurse to find it.<br><br>On September 14, 2023, at 5:09 p.m., the surveyor again requested the resident's admission assessment. However, no additional assessment documentation was provided.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 01610 | | |
| 01640 SS=F | 144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to<br><br>(a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan.<br>(b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities.<br>(c) The facility must implement and provide all services required by the current service plan.<br>(d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable.<br>(e) Staff providing services must be informed of the current written service plan. | 01640 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 38979 | A. BUILDING: _____ B. WING _____ | 09/14/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LIVE WELL MN HOME HEALTH CARE | 7780 LONG LAKE ROAD MOUNDS VIEW, MN 55112 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
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| 01640 | Continued From page 24<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure the current service plan included a signature or other authentication by the licensee and resident or resident's representative to document agreement of services to be provided for two of two residents (R1, R2).<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><br>The findings include:<br><br>R1<br>R1 was admitted on November 1, 2022.<br><br>R1's undated, unsigned, service plan listed 14 services, including assistance with bathing, dressing, grooming, toileting, transfers, and meals, with an effective date of September 11, 2023.<br><br>Page four of R1's service plan included a section for for the resident or their representative and a facility representative to sign, but all sections were blank.<br><br>R2<br>R2 was admitted on February 27, 2023.<br><br>R2's undated, unsigned, service plan listed five | 01640 | | |

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| 01640 | Continued From page 25<br><br>services, including assistance with ambulation, grooming, bathing, and medication set up, with an effective date of September 11, 2023.<br><br>Page four of R2's service plan included a section for for the resident or their representative and a facility representative to sign, but all sections were blank.<br><br>On September 14, 2023, at 4:40 p.m., licensed assisted living director in residence (LALDIR)-B stated residents would sign a service plan upon admission and R1 and R2 should have copies of the service plan.<br><br>On September 14, 2023, at 5:09 p.m., the surveyor requested R1 and R2's signed service plans, however none were provided.<br><br>No further information provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 01640 | | |
| 02310 SS=D | 144G.91 Subd. 4 (a) Appropriate care and services<br><br>(a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and record review, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards for one of one | 02310 | | |

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| 02310 | Continued From page 26<br>residents (R1) with a hospital bedrail.<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 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>The findings include:<br><br>R1's diagnoses included chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), and degenerative arthritis.<br><br>R1's undated, unsigned, service plan listed 14 services, including assistance with bathing, dressing, grooming, toileting, transfers, and meals, with an effective date of September 11, 2023.<br><br>R1's record contained two assessments related to bedrails.<br><br>R1's Side-Rail Use Assessment form completed November 3, 2022, indicated the resident had poor bed mobility or difficulty moving to a sitting position on the side of the bed and required a bedrail for positioning and support. Page two of the form included a section for side rail measurements and zone 1 was indicated to be less than 4 3/4 inches, however no measurements were recorded. The form further indicated the resident understood the risks of bedrail use. Only one potential risk was marked, the risk of injuries from falls if the resident attempted to climb over the rails. A box for "risk of | 02310 | | |

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| 02310 | Continued From page 27<br><br>strangulation, suffocating, bodily injury or death when resident or part of their body are caught between the rails or between the side rails and mattress" was left unchecked, indicating the resident was not at risk for that concern.<br><br>R1's Bed Safety Assessment completed on September 5, 2023, indicated the resident had "one hand rail for help with turning and repositioning by the patient." A section for bed safety zones of hospital bed systems only was not filled out and was marked "not applicable, either resident has no bed rails in use or has portable bed rails that are installed on a consumer bed."<br><br>On September 11, 2023, at 1:10 p.m., housing manager (HM)-C observed R1's bedrail with the surveyor. The bedrail was attached to the bed frame and spanned the length of the right side of the bed. HM-C stated the nurse would complete a bedrail assessment and the assessment should contain measurements of the bedrail and documentation of risks related to its use.<br><br>On September 11, 2023, at 1:30 p.m., R1 confirmed she used the bedrail for mobility in her bed and could not recall if any risks were discussed with her.<br><br>The licensee's Side rails policy, dated October 10, 2022, indicated staff would assess the use, educate the resident, and when appropriate, the responsible person, regarding the risks and benefits of side rails, and verify that the side rail in use is of a safe design and utilized consistent with the manufacturer's directions.<br><br>The FDA "A Guide to Bed Safety" revised April 2010, included the following information: "When | 02310 | | |

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| 02310 | Continued From page 28<br><br>bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe."<br><br>The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) dated June 20, 2023, indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, "Documentation about a resident's bed rails includes, but is not limited to:<br>- Purpose and intention of the bed rail;<br>- Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail;<br>- The resident's bed rail use/need assessment;<br>- Risk vs. benefits discussion (individualized to each resident's risks);<br>- The resident's preferences;<br>- Installation and use according to manufacturer's guidelines;<br>- Physical inspection of bed rail and mattress for | 02310 | | |

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| 02310 | Continued From page 29<br><br>areas of entrapment, stability, and correct installation; and<br>- Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements."<br>Additionally, the MDH website indicated for hospital-style bed rails, the licensee must include in their documentation, the bed rail measurements and that the bed rail has not shifted and is securely attached to the bed frame per manufacturer recommendations.<br><br>No further information provided.<br><br>TIME PERIOD FOR CORRECTION: Two (2) days | 02310 | | |

Minnesota Department of Health
Environmental Health, FPLS
P.O Box 64975
Saint Paul
651-201-4500

Type: Full
Date: *09/12/23*
Time: 11:25:49
Report: 1018231164

# Food and Beverage Establishment Inspection Report



**Location:**
Live Well MN Home Care
7780 Long Lake Rd
Mounds View, MN55112
Ramsey County, 62

**Establishment Info:**
ID #: 0042016
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.

**3-500C Microbial Control: date marking**

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

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

PACKAGED ITEMS SUCH AS DELI MEAT AND CHEESE OBSERVED WITHOUT DATE MARKS IN THE REFRIGERATOR. COMPLY WITH RULE.

*Comply By: 09/12/23*

**Food and Equipment Temperatures**

Process/Item: Cold Holding/ DELI MEAT
Temperature: 41 Degrees Fahrenheit - Location: REFRIGERATOR
Violation Issued: No

Process/Item: Cold Holding/ EGGS
Temperature: 41 Degrees Fahrenheit - Location: REFRIGERATOR
Violation Issued: No

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

ESTABLISHMENT HAS 4 RESIDENTS CURRENTLY.

ALL FOOD IS SAME DAY SERVICE, NO REHEATING OF PREVIOUSLY COOKED FOODS.

DISHWASHER OBSERVED WITH SANITIZE FUNCTION.

SEPARATE SINKS FOR DISHWASHING AND HAND WASHING.

DISCUSSED EMPLOYEE ILLNESS AND VIEWED ILLNESS LOG.

DISCUSSED PEST CONTROL.

**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 1018231164 of 09/12/23.

Certified Food Protection Manager: BETELCHAM Y WALLE

Certification Number: FM117928 Expires: 07/21/26

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

Signed: _____

BETELCHAM WALLE
OWNER

Signed: _____

Rebecca Prestwood
Sanitarian 3
6512013777
rebecca.prestwood@state.mn.us