Electronically Delivered

June 20, 2023

Licensee
Mercy Link LLC
3149 Columbus Avenue South
Minneapolis, MN 55407

RE: Project Number(s) SL34232015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on June 1, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS
The enclosed State Form documents the state correction orders. The MDH documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

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

The correction order documentation should include the following:

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

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

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

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 state form with your organization's Governing Body.

If you have any questions, please contact me.

Sincerely,

Jonathan Hill, Supervisor
State Evaluation Team
Email: jonathan.hill@state.mn.us
Telephone: 651-201-3993 Fax: 651-281-9796

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34232	A. BUILDING: _____ B. WING _____	06/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERCY LINK LLC	3149 COLUMBUS AVENUE SOUTH MINNEAPOLIS, MN 55407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL34232015-0 On May 30th, 2023, through June 1st, 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 (4) residents receiving services under the provider's Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level pursuant to 144G.31 Subd. 1, 2 and 3.	
0 430 SS=F	144G.40 Subd. 2 Uniform checklist disclosure of services (a) All assisted living facilities must provide to prospective residents: (1) a disclosure of the categories of assisted	0 430		

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0 430	Continued From page 1 living licenses available and the category of license held by the facility; (2) a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and (3) an oral explanation of the services offered under the contract. (b) The requirements of paragraph (a) must be completed prior to the execution of the assisted living contract. (c) The commissioner must, in consultation with all interested stakeholders, design the uniform checklist disclosure form for use as provided under paragraph (a). This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to provide a current copy of the uniform checklist disclosure of services with the required content for two of two residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 and R2's records lacked a uniform checklist disclosure of services to include:	0 430		

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0 430	Continued From page 2 - a disclosure of the categories of assisted living licenses available and the category of license held by the facility; and - a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide. R1's diagnoses included major cognitive disorder (a disorder that affects daily functioning and independence) due to traumatic brain injury. R1's service plan, dated May 15th, 2023, indicated the resident received services which included medication administration. On May 31st, 2023, at 8:10 a.m., unlicensed personnel (ULP)-C was observed to assist R1 with medication administration. R2's diagnoses included major neurocognitive disorder (disorder that affects daily functioning and independence) due to traumatic brain injury. R2's service plan dated January 2nd, 2023, indicated the resident received services which included medication administration. On May 31st, 2023, at 8:00 a.m., ULP-C was observed to assist R2 with medication administration. On June 1, 2023, at 9:12 a.m., licensed assisted living director (LALD)-A stated they were using the Uniform Consumer Information Guide and not the Uniform Disclosure of Assisted Living Services and Amenities form as required. No further information was provided.	0 430		

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0 430	Continued From page 3 TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 430		
0 480 SS=D	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated May 30th, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		

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0 680	Continued From page 4	0 680		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to have a written emergency preparedness plan (EP) with all the required content and failed to post an emergency preparedness plan prominently. This had the potential to affect all four residents, staff and visitors. This practice resulted in a level two violation (a	0 680		

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0 680	Continued From page 5 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On May 30th, at 10:00 a.m., a request was made to view the licensee's emergency preparedness plan, which was later reviewed by the surveyor. The licensee's plan lacked the following required content: -a risk assessment considering all hazards that may impact all or a portion of the facility -handling and use of volunteers -a process for emergency preparedness cooperation with state and local EP officials/organizations -procedures for sharing medical information to maintain continuity of care; and procedures for sharing the emergency plan with family members and residents. -EP testing requirements including an annual full-scale exercise or individual facility-based functional exercise During an interview on June 1st, 2023, at 11:30 a.m., licensed assisted living director (LALD)-A stated the emergency preparedness manual had not been developed to include all the required information and was not posted in a prominent location. The licensee's Emergency Preparedness policy dated May 26, 2020, indicated the licensee would	0 680		

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0 680	Continued From page 6 post and Emergency Disaster Plan at each residence and would conduct a disaster drill at least annually. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced	0 780		

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0 780	Continued From page 7 by: Based on observation and interview, the licensee failed to provide smoke alarms that are interconnected so that the actuation of one alarm causes all alarms in the dwelling unit to actuate. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On May 31, 2023, approximately from 10:30 a.m. to 11:30 a.m., survey staff toured the facility with the Licensed Assisted Living Director (LALD)-A. It was observed that the smoke alarms throughout the home were not interconnected with each other so the actuation of one alarm would cause all alarms to operate. This deficient condition was visually verified by LALD-A accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of	0 800		

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0 800	Continued From page 8 good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when 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: On May 31, 2023, approximately from 10:30 a.m. to 11:30 a.m., survey staff toured the facility with the Licensed Assisted Living Director (LALD)-A. It was observed that the carpet in the main level living room was not fully adhered to the floor and was bunching around the column and at the transition strip adjacent to the dining room. The carpet was also stained in multiple locations and showed wear patterns in high-traffic areas. Loose and worn carpeting is a potential tripping hazard.	0 800		

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0 800	Continued From page 9 It was observed that the carpet on the stairs going up to the second level was not fully adhered to all the steps and the lower landing. The carpet was also stained in multiple locations and heavily soiled on multiple steps. Loose carpeting on the stairs is a potential tripping hazard. It was observed in the upstairs bathroom that the drywall in the shower had water or steam damage. The drywall was cracked and curling away from the edge of the show enclosure leaving a gap for water to get behind the shower enclosure. The drywall behind the bathroom door had a hole in it from the door knob. The windowsill and flooring next to the window had small burn marks from residents smoking in the bathroom next to the window. LALD-A stated that they were having struggles with residents smoking in the bathroom in winter. It was observed that the shower attached to bedroom #3 was starting to have similar water damage as the other shower upstairs. The drywall was starting to crack and wrinkle from water or steam in the shower. It was observed that the window wells in bedrooms #4 and #5 were overgrown with plants and weeds. The egress windows were difficult to operate due to the overgrowth. It was observed that the fence gate did not open completely to allow access to and from the building. The gate opened just over halfway before catching on the concrete sidewalk. LALD-A visually verified these deficient findings at the time of discovery.	0 800		

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0 800	Continued From page 10 TIME PERIOD FOR CORRECTION: Seven (7) days.	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill.	0 810		

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0 810	Continued From page 11 This MN Requirement is not met as evidenced by: Based on a record review and interview, the licensee failed to develop a fire safety and evacuation plan with the required elements, failed to provide required employee and resident training on fire safety and evacuation, and failed to conduct required evacuation drills. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to 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: A record review and interview were conducted on May 31, 2023, at approximately 12:00 p.m. with the licensed assisted living director (LALD)-A on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. Record review of the available documentation indicated that the licensee did not have employee actions to be taken in the event of a fire or similar emergency. The facility plan indicated to use RACE acronym but was very vague and did not provide complete actions for employees to take in the event of a fire or similar emergency. During interview, LALD-A verified that the fire safety and evacuation plan for the facility lacked these provisions.	0 810		

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0 810	Continued From page 12 Record review of the available documentation indicated that the licensee did not have fire protection procedures necessary for residents included in the fire safety and evacuation plan. During interview, LALD-A verified that the fire safety and evacuation plan for the facility lacked these provisions. Record review of the available documentation indicated that the fire safety and evacuation plan did not include procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. The facility plan did include some provisions for the relocation of residents but did not specify how to move or evacuate residents or identify the unique and unusual needs of the residents. During interview, LALD-A verified that the fire safety and evacuation plan for the facility lacked these provisions. Record review of available documentation indicated that the licensee did not provide employee training on the fire safety and evacuation plan twice per year after the training at initial hire. During interview, LALD-A stated the licensee did not have any documented training of employees. Record review of the available documentation indicated that the licensee did not provide 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. During interview, LALD-A stated that the facility did not have documentation on offering resident training	0 810		

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	34232	A. BUILDING: _____ B. WING _____	06/01/2023

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0 810	Continued From page 13 on the fire safety and evacuation plan. Record review of the available documentation indicated that the licensee did not conduct evacuation drills twice per year per shift and every other month as required by statute. Provided documentation indicated that drills were completed on 01-02-23, 03-01-23, and 05.01.23. During interview, LALD-A verified that there were no further documented drills for the facility and verified this deficient condition. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
0 820 SS=F	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure physical facility elements did not constitute a distinct hazard to life. Licensee failed to provide fire-rated ashtrays for resident use in	0 820		

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0 820	Continued From page 14 smoking areas. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On May 31, 2023, approximately from 10:30 a.m. to 11:30 a.m., survey staff toured the facility with the Licensed Assisted Living Director (LALD)-A, it was also observed that the main level wooden deck was being used as a smoking area for residents. There was a small plastic bucket filled with sand and additional cigarette butts being used as an ashtray. LALD-A stated that residents would smoke on the deck and used the small bucket as an ashtray. Survey staff explained to the licensee that a fire-rated ashtray should be provided for resident use and that the discarded cigarette butts were a potential fire hazard if cigarettes were not completely extinguished before discarding them. LALD-A visually verified these deficient findings at the time of discovery. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 820		
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited	0 970		

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0 970	Continued From page 15 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. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the contract did not include language waiving the licensee's liability for health, safety, or personal property of a resident. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On May 30th at 10:00 a.m., a copy of the the facility's contract was requested. The contract included an indemnification clause that indicated the facility "shall not be liable for any damage or injury to the resident, or any other person, or to any property, occurring on the premises." The contract further indicated "resident agrees to be liable and responsible for all obligations herein referenced, monetary and	0 970		

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0 970	Continued From page 16 otherwise." On May 31st, at 1:00 p.m., licensed assisted living director (LALD)-A stated the licensee's assisted living contract contained a waiver of liability. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 970		
01320 SS=D	144G.60 Subd. 4 (a) Unlicensed personnel (a) Unlicensed personnel providing assisted living services must have: (1) successfully completed a training and competency evaluation appropriate to the services provided by the facility and the topics listed in section 144G.61, subdivision 2, paragraph (a); or (2) demonstrated competency by satisfactorily completing a written or oral test on the tasks the unlicensed personnel will perform and on the topics listed in section 144G.61, subdivision 2, paragraph (a); and successfully demonstrated competency on topics in section 144G.61, subdivision 2, paragraph (a), clauses (5), (7), and (8), by a practical skills test. Unlicensed personnel who only provide assisted living services listed in section 144G.08, subdivision 9, clauses (1) to (5), shall not perform delegated nursing or therapy tasks. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure one of one unlicensed personnel (ULP)-C, completed	01320		

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01320	Continued From page 17 training and competency evaluations in all required training topics. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-C had a hire date of July 14, 2021. On May 31, 2023, ULP-C was observed assisting with morning medication administration. ULP-C's record lacked documentation of completed training and competency testing in topics listed in 144G.61 subdivision 2, paragraph (a). - maintenance of a clean and safe environment - understanding appropriate boundaries between staff and clients and the client's family On June 1, 2023, at 10:40 a.m., registered nurse (RN)-B stated ULP-C's record lacked evidence of completed training and competency testing in topics noted above. The licensee's Staff Orientation and Education policy dated May 26, 2020, indicated all clinical topics would be addressed by the RN. No further information was provided. TIME PERIOD FOR CORRECTION:	01320		

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01320	Continued From page 18 Twenty-One (21) days	01320		
01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a),	01500		

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01500	Continued From page 19 annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure annual training included all required topics for each 12 months of employment for one of one unlicensed personnel (ULP)-C. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include:	01500		

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01500	Continued From page 20 ULP-C had a hire date of July 14, 2021. On May 31, 2023, ULP-C was observed assisting with morning medication administration. ULP-C's record lacked documentation of completed annual training as listed in 144G.63 subdivision 5. ULP-C's employee training records lacked evidence ULP-C had successfully completed annual training as required, in the following topics: -review of the assisted living bill of rights -review of provider's policies and procedures -how to communicate with residents who have dementia, Alzheimer's disease, or related disorders On June 1, 2023, at 10:40 a.m., registered nurse (RN)-B stated ULP-C's record lacked evidence of completed annual training in topics noted above. The licensee's Staff Orientation and Education policy dated May 26, 2020, indicated orientation topics were to include a review of the home care bill of rights, and a review of the provider's policies and procedures. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted	01760		

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01760	Continued From page 21 living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure medications were transcribed as prescribed for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's prescriber order dated May 26, 2023, included an order for lisinopril (treatment for hypertension) 5 milligrams (mg) by mouth daily. On May 31st, 2023, at 8:10 a.m., unlicensed personnel (ULP)-C was observed to administer R1's scheduled morning medications, which	01760		

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01760	Continued From page 22 included lisinopril 5 mg; however, R1's medication administration record (MAR) indicated the order as lisinopril 20 mg by mouth daily. On June 1, 2023, at 9:15 a.m., registered nurse (RN)-B stated R1's MAR had not been transcribed to include the new order. The licensee's Medication Orders policy dated 2021, indicated when a written prescription was received it would be recorded or placed into the resident's clinical record by the RN. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
02240 SS=F	144G.90 Subdivision 1 Assisted living bill of rights; notification (a) An assisted living facility must provide the resident a written notice of the rights under section 144G.91 before the initiation of services to that resident. The facility shall make all reasonable efforts to provide notice of the rights to the resident in a language the resident can understand. (b) In addition to the text of the assisted living bill of rights in section 144G.91, the notice shall also contain the following statement describing how to file a complaint or report suspected abuse: "If you want to report suspected abuse, neglect, or financial exploitation, you may contact the Minnesota Adult Abuse Reporting Center (MAARC). If you have a complaint about the facility or person providing your services, you may contact the Office of Health Facility Complaints, Minnesota Department of Health. If you would like	02240		

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02240	Continued From page 23 to request advocacy services, you may contact the Office of Ombudsman for Long-Term Care or the Office of Ombudsman for Mental Health and Developmental Disabilities." (c) The statement must include contact information for the Minnesota Adult Abuse Reporting Center and the telephone number, website address, email address, mailing address, and street address of the Office of Health Facility Complaints at the Minnesota Department of Health, the Office of Ombudsman for Long-Term Care, and the Office of Ombudsman for Mental Health and Developmental Disabilities. The statement must include the facility's name, address, email, telephone number, and name or title of the person at the facility to whom problems or complaints may be directed. It must also include a statement that the facility will not retaliate because of a complaint. (d) A facility must obtain written acknowledgment from the resident of the resident's receipt of the assisted living bill of rights or shall document why an acknowledgment cannot be obtained. Acknowledgment of receipt shall be retained in the resident's record. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the current Minnesota Bill of Rights for Assisted Living Residents was provided to the resident for two of two residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems	02240		

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02240	Continued From page 24 are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee had a current assisted living license effective January 1st, 2023. R1 R1's service plan, dated May 15th, 2023, indicated the resident received services which included medication administration. On May 31st, 2023, at 8:10 a.m., unlicensed personnel (ULP)-C was observed to assist R1 with medication administration. R1's record included a signed copy, dated May 15th, 2023, of the Health Care Bill of Rights for Residents of Supervised Living Facilities. R2 R2's service plan dated January 2nd, 2023, indicated the resident received services which included medication administration. On May 31st, 2023, at 8:00 a.m., ULP-C was observed to assist R2 with medication administration. R2's record included a signed copy, dated January 1st, 2023, of the Health Care Bill of Rights for Residents of Supervised Living Facilities. On May 31st, 2023, at 12:30 p.m., licensed assisted living director (LALD)-A stated the licensee did not use the current Minnesota Bill of Rights for Assisted Living Residents.	02240		

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02240	Continued From page 25 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02240		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure the required notice was posted at the main entry way of the facility to display statutory language to disclose electronic monitoring activity, potentially affecting all current residents in the assisted living facility, staff and any visitors of the licensee. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the client and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On May 30th, 2023, at 10:00 a.m., during the	03090		

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03090	Continued From page 26 entrance conference, licensed assisted living director (LALD)-A stated the licensee's registered nurse (RN) might use the facility's camera footage to review a fall. On May 30, 2023, at 11:15 a.m., during a facility tour, the licensee's main entry way was observed to lack signage to notify visitors of electronic monitoring. On May 30, 2023, at 12:45p.m., licensed assisted living director (LALD)-A stated the licensee had failed to post the electronic monitoring signage as required. The licensee's Electronic Monitoring Policy dated May 26, 2020, indicated the licensee would post a sign at the facility entrance with the required notification. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	03090		

DEPARTMENT OF HEALTH

Minnesota Department of Health
Environmental Health, FPLS
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *05/30/23*
Time: 11:40:00
Report: 10392354

Food and Beverage Establishment Inspection Report

Location:
Mercy Link Llc
3149 Columbus Avenue South
Minneapolis, MN55407
Hennepin County, 27

Establishment Info:
ID #: 0039366
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 9522225477
ID #:

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

The following orders were issued during this inspection.

4-700 Sanitizing Equipment and Utensils

4-702.11 ***** Priority 1 *****

MN Rule 4626.0900 Sanitize utensils and food contact surfaces of equipment before use, after cleaning.

CUTTING BOARDS ARE BEING WASHED BY HAND WITH DISH SOAP AND RINSED. DISCUSSED USING DISH WASHING MACHINE WITH SANITIZE SETTING ON FOR ALL DISH WASHING.

Comply By: 05/30/23

7-200 Toxic Supplies and Applications

7-201.11B ***** Priority 1 *****

MN Rule 4626.1600B Discontinue storing poisonous or toxic materials above food, equipment, utensils, linens or single-service or single-use articles.

DRY STORAGE CLOSET HAD CLEANING CHEMICALS AND GRILL STARTER FLUID ABOVE DRY FOOD, UTENSILS AND SINGLE-USE ARTICLES. STAFF MOVED CHEMICALS AND STARTER FLUID TO BE BELOW ALL FOOD ITEMS. CORRECTED ON SITE

Comply By: 05/30/23

4-300 Equipment Numbers and Capacities

4-302.12B ***** Priority 2 *****

MN Rule 4626.0705B Provide a readily accessible food temperature measuring device with a small diameter probe to measure the temperature in thin foods such as meat patties and fish fillets.

STAFF STATES A FOOD THERMOMETER IS KEPT AT ESTABLISHMENT BUT WASN'T ON HAND DURING INSPECTION. STAFF PLANS TO FIND OR REPLACE THERMOMETER.

Comply By: 07/31/23

2-100 Supervision

2-102.12DMN

MN Rule 4626.0033D Post the certified food protection manager certificate.

A COMPUTER SCREENSHOT OF CFPM DETAILS WAS AVAILABLE BUT NO CERTIFICATE WAS ON HAND.

Comply By: 07/31/23

Food and Equipment Temperatures

Process/Item: MILK
Temperature: 39 Degrees Fahrenheit - Location: COLD HOLD REFRIGERATOR
Violation Issued: No

Process/Item: BACON
Temperature: 37 Degrees Fahrenheit - Location: COLD HOLD REFRIGERATOR
Violation Issued: No

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

The inspection was completed with staff and reviewed with MDH Nurse Tammy Carlson.

The establishment has a residential kitchen and serves food that is prepared that day. The kitchen has laminate wood cabinets with hollow base, wood laminate floor, painted walls and ceiling and laminate counter tops.

The kitchen finishes and surfaces are well maintained.

The kitchen refrigerator/freezer are of residential grade.

A 2-compartment sink is present in kitchen. A bathroom sink immediately off the kitchen is designated for hand washing.

An NSF residential dish machine is located in the kitchen. Staff states the dish machine utensil surface temperature reaches 170 degrees F measured by indicator paper. Dish machine must be used with sanitize option turned on.

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 10392354 of 05/30/23.

Certified Food Protection Manager: Jibriil Ahmed Yusuf

Certification Number: FM108873 Expires: 12/01/24

Inspection report reviewed with person in charge and emailed.

Signed: _____

Adam Jama
Person-In-Charge

Signed: _____

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