



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

November 13, 2024

Licensee

St. John Home Care LLC
2464 Hemlock Lane North
Plymouth, MN 55441

RE: Project Number(s) SL36867015

Dear Licensee:

On October 9, 2024, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on August 2, 2024. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the August 2, 2024 survey.

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.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on August 2, 2024, found not corrected at the time of the October 9, 2024, follow-up survey and/or subject to penalty assessment are as follows:

0470-Minimum Requirements-144g.41 Subdivision 1 - \$500.00
0650-Employee Records-144g.42 Subd. 8
0660-Tuberculosis Prevention And Control-144g.42 Subd. 9 - \$500.00
0680-Disaster Planning And Emergency Preparedness-144g.42 Subd. 10 - \$500.00
1290-Background Studies Required-144g.60 Subdivision 1
1820-Prescriptions-144g.71 Subd. 13
2310-Appropriate Care And Services-144g.91 Subd. 4 (a) - \$500.00
3090-Notice To Visitors-144.6502, Subd. 8

The details of the violations noted at the time of this follow-up survey completed on October 9, 2024 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Also, at the time of this follow-up survey completed on October 9, 2024, we identified the following violation(s):

0340-Correction Orders-144g.30 Subd. 5 - \$500.00

0780-Fire Protection And Physical Environment-144g.45 Subd. 2 (a) (1)

0800-Fire Protection And Physical Environment-144g.45 Subd. 2 (a) (4)

1440-Supervision Of Staff Providing Delegated Nurs-144g.62 Subd. 4

1890-Prescription Drugs-144g.71 Subd. 20

1910-Disposition Of Medications-144g.71 Subd. 22

The details of the violation(s) noted at the time of this follow-up survey are delineated on the attached State Form. Only the ID Prefix Tag in the left hand column without brackets will identify these state correction orders. It is not necessary to develop a plan of correction.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$2,500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

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

IMPOSITION OF FINES:

Level 1: no fines or enforcement.

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

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

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

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

To submit a reconsideration request, please visit:

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

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. to submit a hearing request, please visit:

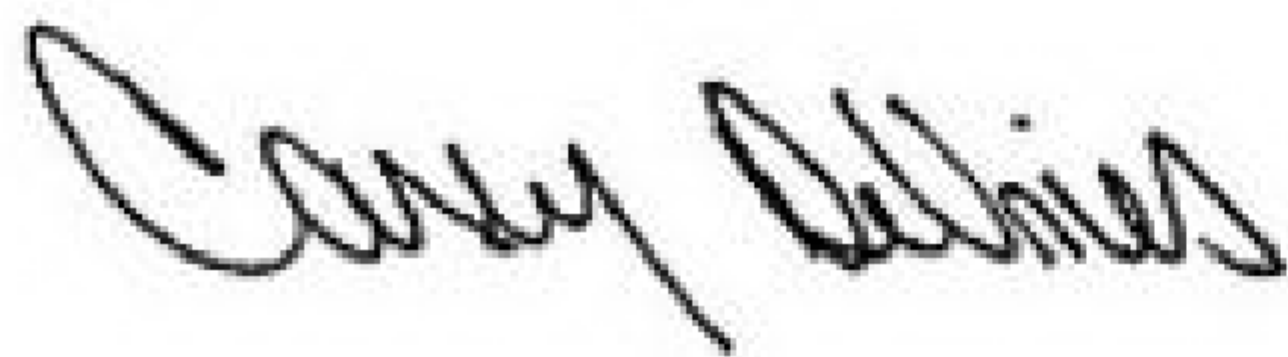
<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

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

We urge you to review these orders carefully. If you have questions, please contact Casey DeVries at 651-201-5917.

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

Sincerely,



Casey DeVries, Supervisor
State Evaluation Team
Email: Casey.DeVries@state.mn.us
Telephone: 651-201-5917 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36867	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 10/09/2024
NAME OF PROVIDER OR SUPPLIER ST JOHN HOME CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 2464 HEMLOCK LANE NORTH PLYMOUTH, MN 55441		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
{0 000}	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL36867015-1 On October 8, 2024, through October 9, 2024, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on August 2, 2024. At the time of the survey, there were four residents all of whom received services under the Assisted Living license. As a result of the follow-up survey, the following orders were issued/reissued.	{0 000}	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
0 340 SS=F	144G.30 Subd. 5 Correction orders a) A correction order may be issued whenever the	0 340			

Minnesota Department of Health

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

TITLE

(X6) DATE

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0 340	Continued From page 1 commissioner finds upon survey or during a complaint investigation that a facility, a managerial official, an agent of the facility, or an employee of the facility is not in compliance with this chapter. The correction order shall cite the specific statute and document areas of noncompliance and the time allowed for correction. (b) The commissioner shall mail or email copies of any correction order to the facility within 30 calendar days after the survey exit date. A copy of each correction order and copies of any documentation supplied to the commissioner shall be kept on file by the facility and public documents shall be made available for viewing by any person upon request. Copies may be kept electronically. (c) By the correction order date, the facility must document in the facility's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the facility's action to respond to the correction order in future surveys, upon a complaint investigation, and as otherwise needed. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to have sufficient documentation with actions taken to comply with the correction orders for a survey completed on August 2, 2024. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected	0 340			

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0 340	Continued From page 2 or has the potential to affect a large portion or all of the residents). The findings include: Throughout the survey, in addition to verbal requests, the surveyor requested the licensee's documentation of any action taken to comply with the correction orders (plan of correction) via email on October 8, 2024, at 9:28 a.m., 12:56 p.m., and 1:54 p.m., and on October 9, 2024, at 9:14 a.m. On October 9, 2024, at 8:15 a.m., the surveyor requested the licensee's plan of correction. Licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated they would look for it. On October 9, 2024, at 8:50 a.m., the surveyor requested the licensee's plan of correction. LALD/CNS-A stated they were looking for it. On October 9, 2024, at 10:57 a.m., the surveyor requested the licensee's plan of correction. LALD/CNS-A inquired what the plan of correction contained. The surveyor described a plan of correction to LALD/CNS-A. LALD/CNS-A stated ok, and they were looking for it. On October 9, 2024, at 11:03 a.m., LALD/CNS-A inquired if they had 90 days to make all corrections on the citations issued during the initial survey. The surveyor explained the time period of correction to LALD/CNS-A. LALD/CNS-A stated they did not understand how the time period of correction worked prior to the explanation. LALD/CNS-A inquired what would occur if the licensee could not complete corrections within the time frame. In addition, LALD/CNS-A stated they had multiple facilities	0 340			

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0 340	Continued From page 3 recently surveyed and it was "overwhelming". On October 9, 2024, at 11:41 a.m., LALD/CNS-A stated, "I have not started the plan yet." LALD/CNS-A stated they made some corrections based on the initial survey exit conference however, they had not reviewed the correction orders issued by the Minnesota Department of Health (MDH) in detail. On October 9, 2024, the follow-up survey concluded, and the following correction orders were reissued: 0470, 0650, 0660, 0680, 0780, 0800, 1290, 1820, 2310, 3090. In addition, 0340, 1140, 1890, 1910 were issued. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 340			
{0 470} SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (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 (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; (12) ensure that one or more persons are available 24 hours per day, seven days per week,	{0 470}			

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{0 470}	Continued From page 4 who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (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; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement a staffing plan for determining its staffing level that included an evaluation completed by a registered nurse (RN) at least twice a year (as indicated in Minnesota Administrative Rule 4659.0180). 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 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: The licensee's undated, unsigned, Staffing Plan indicated two unlicensed personnel (ULP) would be present during the day shift from 7:00 a.m. to 3:30 p.m., and evening shift from 3:00 p.m. to	{0 470}			

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{0 470}	Continued From page 5 11:30 p.m., with one ULP transporting residents and one ULP to remain on premises at all times. One ULP would be present at the facility on the overnight shift from 11:00 p.m. to 7:30 a.m. An on-call nurse would be available 24 hours per day seven days per week. In addition, the plan included information about "pool staff" if needed. The staffing plan lacked evidence of an evaluation conducted by the CNS, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility. On October 9, 2024, at 11:11 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated they reviewed the staffing plan when issues arose. LALD/CNS-C stated they could not remember the frequency the plan was supposed to be reviewed however, they reviewed it four or five times in the year. LALD/CNS-A stated they did not have documentation of when the plan was reviewed, who created the plan, or what metrics were considered when determining staffing levels. The licensee's 4.06 Staffing & Scheduling policy dated October 1, 2021, indicated the CNS would develop and implement a written staffing plan that provides an adequate number of qualified direct-care staff to meet the residents' needs 24-hours a day, seven-days a week. No further information was provided.	{0 470}			
{0 480} SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according	{0 480}			

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{0 480}	Continued From page 6 to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by:	{0 480}	Not reviewed during this survey.		
{0 650} SS=D	144G.42 Subd. 8 Employee records (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: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (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 (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure required annual training documentation was included in	{0 650}			

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{0 650}	Continued From page 7 employee records for one of three employees (unlicensed personnel (ULP)-B). 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-B was hired on May 22, 2022, to provide direct cares to residents. ULP-B's employee record lacked the following required content: - Annual training for 2023 or 2024 on the following topics: - reporting maltreatment of vulnerable adults or minors; - infection control techniques; and - effective approaches to use to problems solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders. - review of providers policies and procedures; - principle of person-centered planning/service delivery. On October 9, 2024, at 8:16 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated ULP-B was signed up in EduCare (a training software program) however, had not completed any annual training in it.	{0 650}			

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{0 650}	Continued From page 8 On October 9, 2024, at 7:54 a.m., the surveyor attempted to contact ULP-B for an interview. The surveyor did not receive a call back prior to the completion of the survey. During the initial survey on August 1, 2024, at 8:40 a.m., ULP-B stated they completed all of their annual training. The licensee's 4.05 Employee Records policy dated October 1, 2021, indicated employee records would include annual training and records of all trainings and in-service education required an/or provided. No further information was provided.	{0 650}			
{0 660} SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by:	{0 660}			

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{0 660}	Continued From page 9 Based on interview and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), which included a two-step tuberculin skin test (TST) or other evidence of TB screening such as a blood test for three of three employees (licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A, unlicensed personnel (ULP)-B, ULP-G). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee's facility TB risk assessment dated July 1, 2024, indicated the facility was at a low risk level. LALD/CNS-A LALD/CNS-A was hired on July 18, 2021, to perform administrative duties, clinical duties, and to provide oversight to unlicensed personnel. LALD/CNS-A's employee record lacked a two-step tuberculin skin test (TST) or other evidence of TB screening such as a blood test. ULP-B ULP-B was hired on May 22, 2022, to provide direct cares to residents.	{0 660}			

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{0 660}	Continued From page 10 ULP-B's employee record included a TB Gold Plus (blood test) with a negative test result dated December 16, 2021. The test was completed 157 days prior to ULP-B's date of hire. ULP-G ULP-G was hired on August 30, 2024, to provide direct cares to residents. ULP-G's employee record included a one-step TST dated September 3, 2024. ULP-G record lacked a second TST. On October 9, 2024, at 11:21 a.m., LALD/CNS-A stated their process related to TB testing was when an employee is hired they are asked to complete a TB test. LALD/CNS-A stated an employee "is not official until the TB screen is here." LALD/CNS-A did not answer the surveyor's question related to their own TB records and began to discuss other employees TB records. LALD/CNS-A stated they asked ULP-B to complete another TB test after the initial survey however, ULP-B had not completed one yet. The surveyor inquired about ULP-G only having one of the two TSTs completed. LALD/CNS-A stated, "sometimes I forget, and I just had them do the one." LALD/CNS-A stated they had forgotten to remind multiple staff members to get the second step TST. The CDC document titled Clinical Testing Guidance for Tuberculosis Health Care Personnel dated December 15, 2023, indicated all health personnel should be screened for TB upon hire. The Minnesota Department of Health Tuberculosis Screening FAQ, dated September 26, 2024, indicated a TST or blood test completed prior to hire would be acceptable if it	{0 660}			

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{0 660}	Continued From page 11 was completed within 90 days before hire date. The licensee's 4.05 Employee Records policy dated October 1, 2021, indicated, "For individuals providing Assisted Living services, verification that required health screenings for Tuberculosis (TB) have taken place and the dates of those screenings. (recommended to keep medical information in a separate employee medical file)." The licensee's 8.16 Tuberculosis Screening policy dated October 1, 2021, indicated, "Staff whose essential job functions require work within the same air space of home care clients will be screened and tested for tuberculosis prior to the staff being exposed to clients." No further information was provided.	{0 660}			
{0 680} SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff	{0 680}			

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{0 680}	Continued From page 12 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 interview and record review, the licensee failed to develop a written emergency preparedness plan (EPP) with all the required content and to post it prominently in a conspicuous place for staff, residents, and visitors to view. 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: The licensee's undated EPP lacked evidence of the following required information: - annual review and update; - documentation of the licensee's risk assessment; - all-hazards approach, including emerging infectious diseases (EID), as applicable; - categorization of the various probable risks/hazards by likelihood of occurrence; - development of strategies for addressing facility	{0 680}			

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{0 680}	Continued From page 13 & community-based risks to include staffing surges/shortages, back-up plans; - missing resident plan and quarterly review of the missing resident plan; - subsistence needs for staff and residents to include alternate sources of energy to maintain temperatures, sanitary storage of provisions, sewage and waste disposal; - policy and procedures (P/P) for sheltering in place; - P/P for medical documents; - P/P for volunteers; - roles under a waiver declared by secretary; - development of communication plan; - names and contact information to include residents physicians; - emergency officials contact information; - methods for sharing information; and - emergency prep testing requirements. On October 9, 2024, at 12:05 p.m., the surveyor reviewed the noted required content above with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A. LALD/CNS-A stated they were not aware of all the requirements for the EPP and prior to the surveyor reviewing the statue with them, they believed the licensee's EPP was sufficient. The licensee's 9.01 Emergency Preparedness Plan -Appendix Z Compliance policy dated October 1, 2024, indicated the licensee had in place an effective and compliant EPP. In addition, the EPP would be aligned with the Centers for Medicare and Medicaid Services State Operation Manual Appendix Z. No further information was provided.	{0 680}			

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0 780	Continued From page 14	0 780			
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that are interconnected so that the actuation of one alarm causes all alarms in the dwelling unit to actuate and failed to keep the facility in compliance with the Minnesota Fire Code. These deficient conditions had the ability to affect all staff and residents.	0 780			

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0 780	Continued From page 15 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On a facility tour on October 8, 2024, between 12:10 p.m. and 12:45 p.m. with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A, the following deficient condition was observed: SMOKE ALARMS: The surveyor observed that the smoke alarms in the facility were not interconnected. The surveyor explained to the LALD/CNS-A that all smoke alarms in the facility shall be interconnected with the 120-volt smoke alarms. The deficient condition was visually verified by the LALD/CNS-A accompanying on the tour.	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 good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and	0 800			

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0 800	Continued From page 16 repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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 a facility tour on October 8, 2024, between 12:10 p.m. and 12:45 p.m. with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A, the following deficient condition was observed: The surveyor observed none of the items listed in the July 30, 2024, survey was complete other than providing a disposal container on the front patio. The surveyor explained to the LALD/CNS-A that the noted items shall be fixed. It the bathroom by resident sleeping room 5 on the lower level, it was observed the shower tub	0 800			

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0 800	Continued From page 17 was cracked, causing water to leak onto the adjacent floor and damaging the floor, wall, and base tile. In the bathroom by resident sleeping 4 on the lower level, it was observed that there were mold or similar black stains on the gypsum ceiling with evidence of water damage. The ceiling finish was bubbled, and the paint was cracked. In resident sleeping room 4, it was observed the door was heavily damaged and had holes. During the interview, LALD/CNS-A stated that one of the residents caused the damage, and the resident in room 4 did not want the facility to replace the door. In resident bedroom 6 on the upper level, it was observed the following items: - It was observed that the multiple plug strips were daisy-chained with an extension cord feeding off one of the plug strips to provide power to the microwave, toaster oven, and refrigerator. The plug strips were attached by multiple electrical equipment, creating a fire hazard. - It was observed there were brown stains on the sheetrock ceiling with evidence of water leakage from above the ceiling. - It was observed there were brown stains on the sheetrock ceiling with evidence of water leakage from above the ceiling. - It was observed there were holes in the gypsum ceiling. - It was observed the ceiling electrical box was missing cover, and electrical wires were exposed. The deficient conditions were visually verified by the LALD/CNS-A accompanying on the tour.	0 800			

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{01290}	Continued From page 18	{01290}			
{01290} SS=D	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a background study was submitted and a clearance received in affiliation with the licensee's current health facility identification number (HFID#) for one of five employees (unlicensed personnel (ULP)-B). 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:	{01290}			

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{01290}	Continued From page 19 ULP-B was hired on May 22, 2022, to provide direct care services to residents. R5's Medication Administration Record dated August 1, 2024, to August 31, 2024, indicated ULP-B administered medication to R5 on August 1, 2024. ULP-B's employee record included a background study clearance notice for HFID# 34786. The background study was not affiliated to the licensee's HFID# 36867. On October 8, 2024, at 2:29 p.m., the surveyor observed the licensee's Minnesota Department of Human Services (DHS) NETStudy 2.0 (a web-based system used to submit background study requests) corporate umbrella NETStudy 2.0 roster and observed the following: - ULP-B affiliated to HFID# 34786. On October 9, 2024, at 11:24 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated when a person applied for a job with the licensee, the licensee would conduct an interview and if the licensee wanted to hire the person, they would then conduct a background study. LALD/CNS-A stated the licensee waited for a background study clearance letter prior to allowing the person to work. LALD/CNS-A stated they were aware the background study needed to be affiliated with the licensees HFID#. LALD/CNS-A stated they were still working on affiliating all employees with the correct HFID# and it cost 40 dollars to affiliate each person. The licensee's 4.02 Background Studies policy dated October 1, 2021, indicated no employee may provide direct care services and have	{01290}			

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{01290}	Continued From page 20 independent direct contact with any residents until acceptable result of the background study had been received. The policy lacked information related to an employee being affiliated to the licensee's HFID#. No further information provided.	{01290}			
01440 SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a registered nurse (RN)	01440			

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01440	Continued From page 21 conducted direct supervision of staff performing a delegated task within 30 days of providing services for two of two unlicensed personnel ((ULP)-B, ULP-G). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-B ULP-B was hired on May 22, 2022, to provide direct cares to residents. ULP-B's employee record lacked record of 30-day supervision. R5's Medication Administration Record dated August 1, 2024, August 31, 2024, indicated ULP-B administered medication to R5 on August 1, 2024. ULP-G ULP-G was hired on August 30, 2024, to provide direct cares to residents. ULP-G record lacked a record of 30-day supervision. On October 9, 2024, at 7:48 a.m., ULP-G stated they had been passing medications for a little more than one month. ULP-G stated they thought they received a 30-day supervision by LALD/CNS-C.	01440			

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01440	Continued From page 22 On October 9, 2024, at 7:54 a.m., the surveyor attempted to contact ULP-B for an interview. The surveyor did not receive a call back prior to the completion of the survey. On October 9, 2024, at 11:18 a.m., licensed assisted living director (LALD/CNS)-A stated their practice was to train the ULP, complete a competency evaluation on the delegated task, and within 30 days complete a 30-day supervision. LALD/CNS-C stated the licensee had a form to document 30-day supervisions on however, they did not use the form. LALD/CNS-C stated they were completing ULP supervisions every 30 days and did not document the supervisions. LALD/CNS-A stated ULP-B may have a 30-day supervision documented however, they were in the middle of organizing documents and could not find the 30-day supervision. LALD/CNS-C stated they had not completed their 30-day supervision with ULP-G. The licensee's 4.05 Employee Records policy dated October 1, 2021, indicated the employee record would include records of all training and in-service education required and/or provided including record of competency testing as required. In addition, it would include verification of completed orientation and annual training and competency testing as required. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440			
{01820} SS=D	144G.71 Subd. 13 Prescriptions	{01820}			

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{01820}	Continued From page 23 There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure written or electronically recorded prescriptions were obtained for one of two residents (R4). 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: R4 was admitted to the licensee on January 12, 2021. R4's Service Plan form dated December 11, 2022, indicated R4 received medication services. On October 8, 2024, at 1:22 p.m., the surveyor observed licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A place a telephone call to an unknown person. The surveyor heard LALD/CNS-C request orders for R4 and for them to be faxed over to them as soon as possible. R4's Medication Administration Record (MAR) for	{01820}			

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{01820}	Continued From page 24 October 1, 2024, through October 31, 2024, indicated R4 took the following medications: - hydrocortisone 2.5 percent (%), insert rectally two times a day; - hydroxyzine hydrochloride (HCL) 25 milligrams (mg), take one tablet (25mg) PO every four hours as needed (PRN) for anxiety; - quetiapine fumarate 300 mg, take one tablet (300mg) by mouth (PO) at bedtime; - quetiapine fumarate 100mg, take one tablet (100mg) PO at bedtime PRN for insomnia and agitation; and - trazodone HCL 50mg, take one tablet (50mg) PO at bedtime PRN. R4's record included a Physician's Order pharmacy form dated June 2024. The medications on the form included the medications listed above. The form lacked an authentication from the prescriber. R4's record included two faxed signed prescriptions received on October 8, 2024, during the survey. The prescriptions included quetiapine fumarate 300 mg once a day at bedtime and hydrocortisone 2.5 % external cream insert rectally two times per day. On October 9, 2024, at 11:38 a.m., LALD/CNS-A stated they renew orders yearly with prescribers, a visit summary was sent with each resident to their medical appointments, and the licensee's pharmacy sent a prescription copy when a new order is received. The surveyor inquired why the prescriptions were received during the survey. LALD/CNS-A stated they were trying to organize information from multiple facility locations they owned, and they were unable to locate the orders. LALD/CNS-A stated they called the pharmacy for the order because they believed it	{01820}			

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER ST JOHN HOME CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 2464 HEMLOCK LANE NORTH PLYMOUTH, MN 55441		
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{01820}	Continued From page 25 would be the quickest way to provide the surveyor the information. The licensee's 7.20 Medication & Treatment Orders policy dated August 1, 2021, indicated: "1) The RN is responsible for assuring that: a. current, authorized prescriber orders for medications or treatments administered by the staff are kept on file in the residents' records b. communicated to the resident or responsible party c. educate resident or responsible party on all medication and treatment orders, and d. changes in orders are addressed in the resident's service plan and are communicated to the other staff. 2) An order for medication or treatment must contain the name of the resident, a description of the medication, treatment or therapy to be provided and the frequency, duration, and other information needed to carry out the order. 3) An order for medication or treatment must be dated, signed by the prescriber and must be current and consistent with the resident's nursing assessment. 4) Upon receiving verbal orders or unsigned electronic orders, a licensed nurse will record and sign the order and forward the written order to the prescriber for a signature after receipt of the verbal or electronic order. The licensed nurse will continue to follow-up with the prescriber's office until the signature is received. 5) The licensed nurse will communicate with the prescriber to assure that the prescriber renews a medication or treatment/therapy order at least every 12 months, or more frequently as needed. 6) The licensed nurse will review all medication and treatment orders for progress, effectiveness and necessity on a regular basis and with resident change of condition.	{01820}			

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{01820}	Continued From page 26 7) The license nurse will also monitor and evaluate medication and treatment/therapy orders and services for effectiveness on a regular basis. 8) A residents MAR and TAR will be audited regularly by licensed nurse or designee for documentation compliance." No further information was provided.	{01820}			
01890 SS=E	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to discard expired medication for two of three residents (R6, R7). 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 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). The findings include: On October 8, 2024, at approximately 9:38 a.m.,	01890			

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01890	Continued From page 27 the surveyor observed the medication closet and observed the following expired medications: - R6- one box nicotine transdermal patch 7 milligrams (mg) filled May 11, 2023; - R6- one card of vitamin B-12 1000 micrograms (mcg) filled July 3, 2023; - R6- eight cards of buspirone hydrochloride (HCL) 10 mg filled August 17, 2023; - R6- four cards of Mirtazapine 15 mg filled August 17, 2023; - R6- seven cards of Lithium carbonate 300 mg filled August 17, 2023; - R6- one card of Loratadine 10 mg filled August 20, 2023; and - R7- four cards of Olanzapine 7.5 mg filled May 3, 2023. On October 9, 2024, at 11:26 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated if a medication prescription label did not include an expiration date, the medication was good for one year from the date it was dispensed unless it was a time sensitive medication. LALD/CNS-A stated they reviewed the medication closet weekly and removed expired medications for destruction. The surveyor inquired why the medications listed above were not disposed of. LALD/CNS-A stated they would need to see the medications. After the surveyor showed LALD/CNS-A the medications, LALD/CNS-A did not state to the surveyor why the medications were not disposed of. LALD/CNS-A stated they would remove the medications. The licensee's 7.23 Medication Disposal policy dated October 1, 2021, indicated expired medications managed by the licensee would be disposed of according to the accepted practices of the Minnesota board of Pharmacy and the labels from the containers would be destroyed.	01890			

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01890	Continued From page 28 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890			
01910 SS=F	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to dispose of discharged resident medications timely and failed to provide documentation in the resident's record regarding the disposition of medication to include medication's name, strength, prescription number as applicable, quantity, date of disposition, to	01910			

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01910	Continued From page 29 whom the medications were given, and names of staff and other individuals involved in the disposition for two of two residents (R2, R5). 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: R2 admitted to the licensee on May 7, 2024, and discharged from the licensee on September 6, 2024. R5 admitted to the licensee on January 1, 2021, and discharged from the facility on August 10, 2024. On October 8, 2024, the surveyor observed the licensee's medication closet where unlicensed personnel (ULP) dispensed medication from and observed the following medications: - R2: olanzapine orally disintegrating tablet (ODT) 5 milligrams (mg) dispensed October 5, 2024; and - R5: one card of rosuvastatin calcium 40 mg expired on September 28, 2024, paroxetine hydrochloride (hcl) 10 mg, valacyclovir 1000 mg, amlodipine 10 mg, quetiapine 50 mg, aripiprazole 5mg, Jardiance 10 mg, quetiapine 200 mg, and two cards of doxycycline 100 mg. On October 9, 2024, at 11:26 a.m., the surveyor inquired how long it took the licensee to dispose	01910			

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01910	Continued From page 30 of medications after a resident discharged. Licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated they normally would send the medication with the resident and document the name of the medication and quantity sent with the resident or dispose of the medications within a week. The surveyor inquired why the medications belonging to R2 and R5 were still in the medication closet. LALD/CNS-A stated they did not know why. LALD/CNS-A stated for R5 they instructed the ULP to pack the medications and send them with R5 upon discharge. LALD/CNS-A stated R2 was now located at a sister facility. The surveyor showed LALD/CNS-A the medications in the medication closet for the discharged residents. LALD/CNS-A instructed ULP-G to remove R5's medications and provide them to the pharmacy for destruction. In addition, LALD/CNS-A stated they would take the medication for R2 to their sister facility. The licensee's 7.23 Medication Disposal policy dated October 1, 2021, read, "1. Any current medications being managed by St. John Home Care must be provided to the resident when the resident's service plan ends, or medication management services are no longer part of the service plan. 2.Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. 3.The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances." In addition, the policy read, "Upon disposition, the facility must document in the resident's record the disposition of the expired medication including the	01910			

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01910	Continued From page 31 medication's name, strength, prescription number as applicable, quantity, date of disposition, and names of staff and other individuals involved in the disposition." No further information was provided.	01910			
{02310} SS=F	144G.91 Subd. 4 (a) Appropriate care and services (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. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medical oxygen tanks were secured and stored properly in noncombustible racks to prevent injury to all residents who resided in the assisted living facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an widespread scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On October 8, 2024, at approximately 9:38 a.m., the surveyor observed one secured oxygen	{02310}			

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{02310}	Continued From page 32 cylinder, and three unsecured oxygen cylinders leaning against the wall in R2's room near the doorway. The oxygen canisters lacked proper storage security. On October 9, 2024, at 11:32 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated unlicensed personnel (ULP) were trained to place oxygen cylinders into a rack to prevent tipping. LALD/CNS-A stated after the previous survey they asked ULP to contact the oxygen company to take away extra oxygen tanks or provide a storage rack. LALD/CNS-C stated they did not follow up to ensure the task was completed by the ULP for R2. The Minnesota Department of Health Oxygen Cylinder Storage Requirements dated April 16, 2020, recommends oxygen tanks be secured with racks or by chains. The licensee's 7.40 Oxygen policy dated October 1, 2021, indicated oxygen cylinders and vessels must remain upright at all times. Never tip an oxygen cylinder or vessel on its side or try to roll it to a new location. The licensee's undated 2.40 Oxygen Use & Oxygen Saturation Levels competency evaluation, indicated, "Can be dangerous if allowed to fall over - if damaged, the cylinder can act as a rocket, causing significant structural damage, potential injuries to person, and explosions." It further indicated, "E-tank cylinders must be secured in a carrier or in some other way (e.g., chained to wall) to prevent falling over." No further information was provided.	{02310}			

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{03090}	Continued From page 33	{03090}			
{03090} SS=C	144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a required notice was posted at the main entry way of the facility to display statutory language to disclose electronic monitoring activity. This had the potential to affect all current residents, staff, and visitors to the facility. 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). The findings include: On October 8, 2024, at 9:14 a.m., during a facility tour, the surveyor observed a "WARNING SECURITY CAMERAS IN USE" sign posted on the front entry, and the surveyor observed multiple cameras within the facility. The surveyor observed no electronic monitoring notice posted in the facility with the statutory required language.	{03090}			

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{03090}	Continued From page 34 On October 9, 2024, at 11:35 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated they were aware of the required notice. LALD/CNS-A then handed the surveyor new electronic monitoring signs and stated they were not able to post the signs yet. The surveyor observed the new signs and observed the signs lacked the statutory language. The surveyor explained the statue to LALD/CNS-A. LALD/CNS-A stated they did not know the sign required specific statutory language. The licensee's 2.15 Electronic Monitoring policy dated October 1, 2021, indicated signs are installed at each facility entrance accessible to visitors that state "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons or activities." No further information was provided.	{03090}			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

September 4, 2024

Licensee

St. John Home Care LLC
2464 Hemlock Lane North
Plymouth, MN 55441

RE: Project Number(s) SL36867015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 2, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement.

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

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

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

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

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

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

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

St - 0 - 0470 - 144g.41 Subdivision 1 - Minimum Requirements - \$3,000.00

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - \$500.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$3,500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

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

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this

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

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

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

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

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

If you have any questions, please contact me.

Sincerely,

A handwritten signature in black ink that reads "Casey DeVries". The signature is written in a cursive, flowing style.

Casey DeVries, Supervisor

State Evaluation Team

Email: Casey.DeVries@state.mn.us

Telephone: 651-201-5917 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36867	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/02/2024
NAME OF PROVIDER OR SUPPLIER ST JOHN HOME CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 2464 HEMLOCK LANE NORTH PLYMOUTH, MN 55441		
(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: SL36867015-0 On July 29, 2024, through August 2, 2024, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey there were six residents living at the facility, all six residents received services under the Assisted Living license. Immediate correction orders were identified on July 30, 2024, issued for SL36867015-0, tag identification 0470 and 0820. At the time of survey exit on August 2, 2024, immediacy remained for immediate correction orders 0470 and 0820. On August 13, 2024, the immediacy of correction order 0820 was removed, however non-compliance remained, and the scope and level remained unchanged.	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 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 is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144A.474 SUBDIVISION 11 (b)(1)(2).		

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36867	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/02/2024
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0 470 SS=I	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (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 (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; (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: (i) awake; (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; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure that one or more persons were available 24 hours per day, seven days per week, who were responsible for responding to the requests of residents for assistance with health or safety needs. Additionally, the licensee failed to develop and	0 470			

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0 470	Continued From page 2 implement a written staffing plan using a staffing metrics to determine appropriate staffing levels which was updated twice per year. Lastly, the licensee failed to post their current staff schedule. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee held an assisted living facility license. The facility was licensed for a capacity of six residents, and during the survey had a census of six residents. R2 R2 was admitted to the licensee on May 7, 2024. R2's diagnoses included bipolar disorder and schizoaffective disorders. R2's service plan was not available at the time of request. Licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated R2 was a new admission, and their service plan was at an offsite location. R3 R3 was admitted to the licensee on February 22, 2021. R3's diagnoses included anxiety, post-traumatic stress disorder (PTSD) and major depressive	0 470			

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0 470	Continued From page 3 disorder (MDD). R3's Service Plan form dated December 11, 2022, indicated R3 received services for medication management, laundry, and housekeeping. It also indicated R3 received behavior management services for anxiety, manage orientation issues, manage agitation, verbal aggression, property destruction, and physical aggression. R4 R4 was admitted to the licensee on January 12, 2021. R4's diagnoses included catatonic schizophrenia. R4's Service Plan form dated December 11, 2022, indicated R4 received services for medication management, laundry, and housekeeping. It also indicated R4 received behavior management services for anxiety, manage agitation, verbal aggression, property destruction, and physical aggression. R5 R5 was admitted to the licensee on January 22, 2021. R5's diagnoses included generalized anxiety disorder, borderline personality disorder, and schizoaffective disorder. R5's Service Plan form dated December 12, 2022, indicated R5 received services for medication management, laundry, and housekeeping. It also indicated R5 received behavior management services for anxiety, manage agitation, verbal aggression, property destruction, and physical aggression.	0 470			

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0 470	Continued From page 4 R6 R6 was admitted to the licensee on December 16, 2022. R6's diagnoses included mood disorder, chronic obstructive pulmonary disease (COPD), and acute kidney failure. R6's Service Plan dated December 18, 2022, indicated R6 received services for medication management, money management, housekeeping, laundry, and meet mental health needs. R7 R7 was admitted to the licensee on October 11, 2019. R7's diagnoses included schizophrenia and obsessive-compulsive disorder. R7's Service Plan form dated December 22, 2022, indicated R7 received services for medication management, laundry, and housekeeping. It also indicated R7 received behavior management services for anxiety, manage agitation, verbal aggression, property destruction, and physical aggression. The licensee's July/August 2024 staff schedule, which ranged from July 21, 2024, to August 31, 2024, indicated one staff member was scheduled per shift. On July 29, 2024, at 9:47 a.m., during the entrance conference, licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A (who was also the facility owner) stated they did not have a staffing plan. LALD/CNS-A stated they	0 470			

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0 470	Continued From page 5 had three shifts in a 24-hour period which had varying staffing between one and two staff members; the staffing was determined based on what was going on each day including things like resident appointments, activities, and shopping. LALD/CNS-A stated their staff schedule was posted in the kitchen on their bulletin board. LALD/CNS-A stated their staff shifts were at the following times with each shift overlapping with the previous shift for 30 minutes: -day shift, 7:00 a.m. to 3:30 p.m., one or two staff scheduled; -evening shift, 3:00 p.m. to 11:30 p.m., one or two staff scheduled; and -overnight shift, 11:00 p.m. to 7:30 a.m., one or two staff scheduled. On July 29, 2024, at 10:34 a.m., during the facility tour, the surveyor observed the licensee lacked a posted staff schedule. LALD/CNS-A stated it was usually posted on the bulletin board in the kitchen at all times. On July 29, 2024, at 11:07 a.m., LALD/CNS-A began going through drawers in the kitchen and found a schedule which they provided for the surveyor, but the schedule was for June/July 2024 going only through July 20, 2024. LALD/CNS-A took a current schedule out of their bag. The surveyor requested a copy, but they stated it was incomplete. On July 30, 2024, at 8:21 a.m., the surveyor arrived at the facility. The surveyor knocked on the door multiple times and rang the doorbell, but no one came to the door. The surveyor heard someone yell and thought someone said, "come in." The surveyor entered the facility but could not find a staff member or resident. The surveyor searched all three floors of the three-level house	0 470			

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0 470	Continued From page 6 but could not locate a staff member or resident. The surveyor did not enter the resident's bedrooms. On July 30, 2024, at 8:25 a.m., the surveyor called LALD/CNS-A who stated they were on their way to the facility. The surveyor inquired if there were any staff at the facility. LALD/CNS-A again stated they were on their way and a staff member had been there in the morning. The surveyor again inquired if there was currently a staff member at the facility. LALD/CNS-A repeated they were on their way to the facility and would explain the situation once they arrived. On July 30, 2024, at 8:31 a.m., the surveyor observed LALD/CNS-A pull their vehicle into the facility driveway. The surveyor inquired if another staff member had been at the facility prior to their arrival. LALD/CNS-A stated, "no, it is normal for them to leave the facility alone with no workers for less than one hour." LALD/CNS-A stated they told the overnight staff approximately 30 minutes ago they could leave since they (LALD/CNS-A) were on their way to the facility. LALD/CNS-A stated they were not required to have staff at the facility at all times since their residents were "pretty independent". LALD/CNS-A stated this was a customized living situation and they could leave residents alone for short periods of time as the residents were not heavily reliant on staff. LALD/CNS-A stated staff do leave regularly to take residents places which left the rest of the residents alone for short periods of time. LALD/CNS-A stated they wanted to write up an explanation for the surveyor to explain further what they meant about their staffing and also wanted the overnight unlicensed personnel ((ULP)-C) to do the same. The surveyor requested to please complete their write-up	0 470			

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0 470	Continued From page 7 immediately. On July 30, 2024, at 8:33 a.m., the surveyor observed R2 come out of his bedroom. R2 stated staff did leave the facility which left residents alone and there were times when there were no staff at the facility. R2 stated it didn't happen all of the time, but it did happen occasionally. On July 30, 2024, at 8:57 a.m., LALD/CNS-A stated their residents were all high functioning. LALD/CNS-A stated residents could leave the facility on their own without staff members. LALD/CNS-A stated staff would take residents out of the house on outings to the movies or for walks and staff would let the rest of the residents know to call their cell phone if they needed anything. LALD/CNS-A stated if staff were taking residents on a group outing to a movie, bowling, or the Mall of America, they couldn't cancel the trip just because one person did not want to go. If one resident didn't want to go on the group outing, they would get the resident's permission to be left alone. LALD/CNS-A stated regarding their staff, "they cannot leave a resident alone if the resident doesn't give them permission. The resident needs to approve it." LALD/CNS-A stated at some of their other houses (other facilities) they cannot leave anyone alone at all due to their needs as those residents cannot defend themselves or use the phone on their own. LALD/CNS-A stated, "I don't want you to feel like we are just leaving residents alone all of the time, that is not what is happening at all." On July 30, 2024, at 10:15 a.m., LALD/CNS-A provided the July/August 2024 schedule. On July 30, 2024, at 10:41 a.m., R3 stated they were sleeping when the surveyor arrived and they	0 470			

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0 470	Continued From page 8 woke up around 9:00 a.m., this morning. R3 stated most of the time staff were available at the facility. R3 stated sometimes there were short periods of time when there were no staff at the facility while they took another resident out, but staff notified them they were leaving and let them know they would be alone and could call them if they needed anything. On July 30, 2024, at 11:41 a.m., LALD/CNS-A stated residents were left alone without staff in the facility earlier in the morning before their arrival. LALD/CNS-A stated they no longer wanted to do a write-up explaining the staffing situation. The licensee's 4.06 Staffing & Scheduling policy dated October 1, 2021, indicated: "1. The clinical nurse supervisor will develop and implement a written staffing plan that provides an adequate number of qualified direct-care staff to meet the residents' needs 24-hours a day, seven-days a week. 2. The clinical nurse supervisor must ensure that staffing levels are adequate to address the following: a. Each resident's needs, as identified in the resident's service plan and assisted living contract b. Each resident's acuity level, as determined by the most recent assessment or individualized review c. The ability of staff to timely meet the residents' scheduled and reasonably foreseeable unscheduled needs given the physical layout of the facility premises d. Whether the facility has a secured dementia care unit, and e. Staff experience, training, and competency.	0 470			

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0 470	Continued From page 9 3. The clinical nurse supervisor will develop a 24-hour daily staffing schedule that will identify: a. direct-care staff work schedules for each direct-care staff member showing all work shifts, including days and hours worked, and b. the direct-care staff member's resident assignments or work location. 4. The daily work schedule must be posted, after redacting direct-care staff members' resident assignments, at the beginning of each work shift in a central location in each building of a facility or campus, accessible to staff, residents, volunteers, and the public. The facility shall not disclose any information that is protected by law from public disclosure. 5. Any employee requesting days off should, in writing, give the supervisor requested days off prior to the posting of the schedule. 6. If changes are needed after the posting of the schedule, employees are responsible to find their own qualified and capable replacement. Employees are responsible for filling out the appropriate PTO or trade request form and receive approval from the supervisor. 7. In case of an illness or emergency, employees must notify the supervisor by telephone at least two (2) hours in advance of the scheduled work time. For any reason employees are not available to work your scheduled shift, it is an employee's responsibility to make every attempt to find a St. John Home Care staff person to replace your shift. (Limited exceptions may include hospitalization, personal or family emergencies or death) 8. The supervisor has the authority, or may delegate the authority, to replace an employee with a temporary agency as needed." No further information was provided.	0 470			

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0 470	Continued From page 10	0 470			
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This had the potential to affect all residents of the assisted living facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated June 29, 2024, for the specific Minnesota Food Code deficiencies. The Inspection Report was provided to the licensee on July 31, 2024. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480			

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0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b) The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an infection control program that complied with accepted health care or medical and nursing standards for infection control. The deficient practice had the potential to affect all residents, employees, 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 the potential to affect a large portion or all of the residents). The findings include: The facility was a three-level home. It had one main floor bathroom (bathroom one) and two bathrooms in the basement (bathrooms two and	0 510			

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0 510	Continued From page 12 three). On July 29, 2024, at 10:34 a.m., during the facility tour with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A, the surveyor observed bathroom one lacked paper towels for hand drying. The surveyor observed bathroom two lacked paper towels for hand drying. LALD/CNS-A stated they were having behavioral issues with residents going through hand towels quickly and that was why there were none in the bathrooms. On July 29, 2024, at 11:45 a.m., the surveyor observed bathroom one lacked hand towels for hand drying. LALD/CNS-A stated bathroom one was used by staff and residents. On July 31, 2024, at 10:07 a.m., the surveyor observed bathroom one lacked hand towels for hand drying. On July 31, 2024, at 11:57 a.m., the surveyor observed bathroom one lacked hand towels for hand drying. On August 1, 2024, at 10:00 a.m., the surveyor observed bathroom one and bathroom two, both lacked hand towels for hand drying. On August 2, 2024, at 9:58 a.m., LALD/CNS-A stated they wished the surveyor had requested paper towels. LALD/CNS-A stated they had residents who regularly would use a whole roll or package of paper towels to clean up something on the floor which was a huge waste. LALD/CNS-A stated bathroom three did have paper towels but the other two did not. The Center for Disease Control (CDC) Clinical	0 510			

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0 510	Continued From page 13 Safety: Hand Hygiene for Healthcare Workers webpage, last updated on February 27, 2024, indicated: "Know how to wash hands with soap and water 1. Wet hands with water. 2. Apply the manufacturer recommended amount of product to your hands. 3. Rub hands together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers. 4. Rinse hands with water and use disposable towels to dry. Use a towel to turn off the faucet. 5. Avoid using hot water to prevent drying of the skin." The licensee's 8.09 Hand Washing policy dated October 1, 2021, indicated: "1. Stand away from the sink. Hands and sleeves must not touch the sink 2. Turn on water and adjust to a comfortably warm temperature 3. Wet hands and wrists 4. Apply soap over hands and wrists, working into a generous lather by scrubbing vigorously 5. Use friction and scrub vigorously for at least 20 seconds (long enough to sing 'Happy Birthday' twice) 6. Be sure to clean beneath the fingernails, around the knuckles and along the sides of the fingers and hands 7. Rinse hands and wrists completely under running water to wash away suds and microorganisms 8. DO NOT TURN FAUCETS OFF WITH CLEAN HANDS - see #10 below 9. Pat hands and wrists dry with a paper towel. It is unacceptable to use client towels for drying hands 10. Turn off water using a clean paper towel to prevent recontamination of the hands	0 510			

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0 510	Continued From page 14 11. If leaving a washroom/restroom, use paper towels to grasp door handle upon exit to prevent recontamination of clean hands." No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 510			
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post the 911 emergency phone number near the facility house phone. This had the potential to affect all residents, staff, and visitors at the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive	0 640			

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0 640	Continued From page 15 or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On July 29, 2024, at 9:42 a.m., the surveyor observed a Vtech house phone on a white buffet table underneath the wall hung television in the living room. The phone lacked a 911 posting required to be near all facility house phones. On July 29, 2024, at 11:15 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the facility had three house phones which included the one in the living room. The surveyor explained 911 was required to be posted near all house phones. On August 1, 2024, at 9:21 a.m., the surveyor observed the living room house phone did not have a 911 posting near it. On August 1, 2024, at 1:36 p.m., the surveyor observed the living room house phone did not have a 911 posting near it. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 640			
0 650 SS=F	144G.42 Subd. 8 Employee records (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:	0 650			

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0 650	Continued From page 16 (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (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 (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure required annual training documentation was included in employee records for two of two employees (licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A, unlicensed personnel (ULP)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	0 650			

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0 650	Continued From page 17 LALD/CNS-A LALD/CNS-A was hired on July 18, 2021, to perform administrative duties, clinical duties, and to provide oversight to unlicensed personnel. LALD/CNS-A's employee record lacked required documentation for the following annual training topics: -Reporting maltreatment of vulnerable adults or minors; -Assisted Living Bill of Rights; -Infection control techniques; -Effective approaches to use to problems solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; -Review of provider's policies and procedures; -Principles of person-centered planning/service delivery; and -Hearing loss training (optional). In addition, LALD/CNS-A's employee record Dementia Training Tracking Form indicated LALD/CNS-A last received dementia training on August 14, 2022. ULP-B ULP-B was hired on May 22, 2022, to provide direct cares to residents. ULP-B's employee record lacked required documentation for the following annual training topics: -Reporting maltreatment of vulnerable adults or minors; -Infection control techniques; and -Effective approaches to use to problems solve when working with a resident's challenging	0 650			

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0 650	Continued From page 18 behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders. On July 29 through August 1, 2024, the surveyor observed LALD/CNS-A performing their duties throughout the survey. On August 1, 2024, at 8:40 a.m., the surveyor observed ULP-B attempt to administer R2's medication. R2 refused their medication. ULP-B stated they completed all of their annual training. On July 29, 2024, at 9:47 a.m., LALD/CNS-A stated they were in charge of training employees and employee record keeping. On July 31, 2024, at 11:22 a.m., LALD/CNS-A stated ULP-B completed all of the required annual training, but they did not have it documented like they should have. On July 31, 2024, at 12:57 p.m., LALD/CNS-A stated they did complete their own annual training and would find the documentation to bring to the surveyor the following day. LALD/CNS-A stated they were aware of the annual training requirements. On August 1, 2024, at 8:56 a.m., LALD/CNS-A stated both their own, and ULP-B's, orientation and annual training topics were completed but were not documented. The licensee's 5.10 Training Records policy dated October 1, 2021, indicated: "POLICY: St. John Home Care will maintain a record of staff training and competency required. PROCEDURE: St. John Home Care will document the following information for each	0 650			

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0 650	Continued From page 19 competency evaluation, training, retraining, and orientation topic: 1. Facility name, location, and license number 2. Name of the training topic or training program 3. The training methodology, such as classroom style, web-based training, video, or one--to-one training 4. Date of the training and the competency evaluation, and the total amount of time of the training and competency evaluation 5. Name and title of the instructor and the instructor's signature, and the name and title of the competency evaluator, if different from the instructor, and the evaluator's signature with a statement attesting that the employee successfully completed the training and competency evaluation, and 6. Name and title of the staff person completing the training, and the staff person's signature with a statement attesting that the staff person successfully completed the training as described in the training documentation. 7. Documentation of the completed competency evaluation, training, retraining, or orientation will be provided to the employee at the time the evaluation or training is completed." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650			
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by	0 660			

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0 660	Continued From page 20 the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee TB tests were completed within 90 days prior to their date of hire via Mantoux skin test or blood test for two of two employees (licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A, unlicensed personnel (ULP)-B). Further, the licensee failed to ensure annual TB training was completed for two of two employees (LALD/CNS-A, ULP-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee's facility TB risk assessment dated July 1, 2024, indicated the facility was at a low risk level.	0 660			

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0 660	Continued From page 21 LALD/CNS-A LALD/CNS-A was hired on July 18, 2021, to perform administrative duties, clinical duties, and to provide oversight to unlicensed personnel. LALD/CNS-A's employee record lacked TB testing completed via a Mantoux skin test or blood test. LALD/CNS-A's employee record included TB training completed in their 1.04 Infection Control policy dated October 1, 2021, completed on April 13, 2022. LALD/CNS's employee record lacked annual TB training due to be completed by April 13, 2023, and then again in 2024. ULP-B ULP-B was hired on May 22, 2022, to provide direct cares to residents. ULP-B's employee record included a TB Gold Plus (blood test) with a negative test result dated December 16, 2021. The test was completed 157 days prior to ULP-B's date of hire. ULP-B's employee record included TB training completed in their 1.04 Infection Control policy dated October 1, 2021, completed on June 18, 2022. LALD/CNS's employee record lacked annual TB training due to be completed by June 18, 2023, and then again in 2024. On July 29 through August 1, 2024, the surveyor observed LALD/CNS-A performing their duties throughout the survey. On August 1, 2024, at 8:40 a.m., the surveyor observed ULP-B attempt to administer R2's medication. R2 refused their medication. ULP-B	0 660			

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0 660	Continued From page 22 stated they completed TB annual training. On July 29, 2024, at 9:47 a.m., LALD/CNS-A stated they were in charge of training employees and employee record keeping. On July 31, 2024, at 12:57 p.m., LALD/CNS-A stated ULP-B completed their annual TB training but did not get it documented. LALD/CNS-A stated they were aware of the annual TB training requirement. On August 1, 2024, at 8:56 a.m., LALD/CNS-A stated ULP-B's annual TB training had not been documented but they completed it again yesterday, July 31, 2024, and documented it. LALD/CNS-A stated they had completed annual TB training for themselves but did not have it documented. On August 1, 2024, at 11:14 a.m., LALD/CNS-A stated they could not find their own TB test results but would keep looking for it. LALD/CNS-A stated they know they had the testing completed but could not find the documentation. On August 1, 2024, at 11:51 a.m., the surveyor showed ULP-B's TB Gold Plus test result to LALD/CNS-A. LALD/CNS-A stated they thought TB blood tests and chest x-rays (CXR) were good for three years. The surveyor explained a TB skin and blood test could only be used by a new employer if they were completed within 90 days prior to the date of hire. The CDC Tuberculosis Guidance website, last updated December 15, 2023, indicated all health personnel should receive baseline TB screening and testing upon hire. It further indicated all health care personnel should receive annual TB	0 660			

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0 660	Continued From page 23 education. The Minnesota Department of Health TB FAQ, last updated on April 3, 2024, indicated: -all Minnesota health care personnel should receive TB education annually, regardless of facility risk level classification; and -TB testing should be dated within 90 days before hiring. The licensee's 4.05 Employee Records policy dated October 1, 2021, indicated, "For individuals providing Assisted Living services, verification that required health screenings for Tuberculosis (TB) have taken place and the dates of those screenings. (recommended to keep medical information in a separate employee medical file)" The licensee's 8.16 Tuberculosis Screening policy dated October 1, 2021, indicated, "Staff whose essential job functions require work within the same air space of home care clients will be screened and tested for tuberculosis prior to the staff being exposed to clients." It further indicated, "Staff will be educated regarding TB at the time of hire." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660			
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses	0 680			

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0 680	Continued From page 24 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 develop a written emergency preparedness plan (EPP) with all the required content and to post it prominently in a conspicuous place for staff, residents, and visitors to view. 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).	0 680			

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0 680	Continued From page 25 The findings include: On July 29, 2024, at 11:25 a.m., the surveyor reviewed the licensee's Emergency Plan for [Licensee], undated, which lacked evidence of the following required information: - annual review and update; - documentation of the licensee's risk assessment; - all-hazards approach, including emerging infectious diseases (EID), as applicable; - categorization of the various probable risks/hazards by likelihood of occurrence; - development of strategies for addressing facility & community-based risks (i.e.: evacuation plans, staffing surges/shortages, back-up plans); - quarterly review of the missing resident plan; - designation of a qualified person, who is authorized in writing, to act in the absence of the administrator; - identification of which staff would assume specific roles in another's absence through succession planning and delegation of authority. - process for cooperation and collaboration with local, tribal, regional, State and Federal EP to maintain integrated response; - development and implementation of EP policies/procedures (P/P) based on the EP, risk assessment & communication plan; - shelter in place needs; - development of P/P for at minimum food, water and pharmaceutical supplies; - development of P/P for sewage and waste disposal; - development of P/P for system to track the location of on-duty staff and sheltered residents; - development of P/P for if on-duty staff and sheltered residents are relocated, how the licensee must document the specific	0 680			

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0 680	Continued From page 26 name/location of the receiving facility or other location; - development of P/P to address safe evacuation from the facility, including consideration of care/treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); primary/alternate communication means with external sources of assistance; - development of P/P for shelter in place for residents, staff, and volunteers who remain in the facility; - development of P/P for a system of medical documentation that preserves resident information, protects confidentiality, and secures/maintains availability of records; - development of P/P to address: use of volunteers, including the process/role for integration; - development of P/P to address the role of the licensee under a waiver declared by the Secretary in accordance with section 1135 of the Act; - development of a communication plan to include all of the following: method for sharing information from the emergency plan, that the facility has determined appropriate, with residents and their families/representatives; and -development of a communication plan which included: -method for sharing information and medical documentation for residents under the facility's care, as necessary, with other HCPs to maintain continuity of care -means, in event of evacuation, to release resident information as permitted under 45 CFR 164.510(b)(1)(ii) -means of providing information about general condition/ location of residents under the facility's care as permitted under 45 CFR	0 680			

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0 680	Continued From page 27 164.510(b)(4) -development of a communication plan to included: -federal, state, tribal, regional & local EP staff -state licensing and certification agency -MN Office of Ombudsman for LTC -other sources of assistance On July 29, 2024, at 11:53 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated they had not reviewed or updated the EPP since it was created. LALD/CNS-A stated they would only review or update it if the EPP needed changes. LALD/CNS-A stated they needed to review and update their EPP. On August 1, 2024, at 1:29 p.m., LALD/CNS-A showed the surveyor their emergency food supply. LALD/CNS-A stated they did not have an emergency water supply onsite; it was at another location. LALD/CNS-A stated it was difficult to keep a backup water supply at the facility because everyone kept drinking it. On August 2, 2024, at 9:58 a.m., LALD/CNS-A stated their EPP did not have an all-hazards approach assessment and was unfamiliar with what it was. LALD/CNS-A stated their EPP did not address waiver 1135 and was unfamiliar with what it was. LALD/CNS-A stated their EPP did not include or identify the quantity of backup food, water, and medical supply needed for shelter in place. LALD/CNS-A stated their quarterly missing resident plan was not reviewed quarterly. The licensee's EPP policy, undated, indicated, "THIS COMPREHENSIVE EMERGENCY MANAGEMENT PLAN WAS DEVELOPED IN ACCORDANCE WITH THE REQUIREMENTS	0 680			

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0 680	Continued From page 28 FOR ASSISTED LIVING FACILITIES AS SET FORTH IN RULE 9503.0110 (E) OF THE MINNESOTA ADMINISTRATIVE CODE FOR ASSISTED LIVING FACILITIES." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (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;	0 780			

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0 780	Continued From page 29 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that are interconnected so the actuation of one alarm causes all alarms in the dwelling unit to actuate and failed to provide working smoke alarm in sleeping rooms as required. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On July 30, 2024, at 10:30 a.m., survey staff toured the facility with the licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A. During the tour, it was observed that a working smoke alarm was not installed in the residents' sleeping room 5 on the lower level and the residents' sleeping room 6 on the upper level. A smoke alarm was also not installed immediately outside residents' sleeping room 3 on the main level. During the interview on July 30, 2024, at 11:30 a.m., LALD/CNS-A stated that the residents in the rooms tampered with the smoke alarms so they could smoke in the rooms and visually verified these deficient findings at the time of discovery.	0 780			

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0 780	Continued From page 30 During the tour, it was also observed that upon testing, the smoke alarms in the facility were not interconnected, so the actuation of one smoke alarm would cause all other alarms in the facility to actuate. During the same interview, LALD/CNS-A stated that one type of smoke alarm was interconnected on the main and upper levels, and the other type was installed on the lower level. LALD/CNS-A verified that the smoke alarms in the facility were not interconnected, and the actuation of one alarm would not cause all alarms to operate. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780			
0 790 SS=D	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to perform the required annual and monthly maintenance on fire extinguishers and failed to	0 790			

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0 790	Continued From page 31 provide adequately rated (size) portable fire extinguisher as required for the facility. This had the potential to affect all current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: On July 30, 2024, at 10:30 a.m., survey staff toured the facility with the licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A. During the facility tour, it was observed that the fire extinguisher on the upper level did not have a service tag showing they had been inspected annually and lacked records showing the required monthly visual inspections were performed on the portable fire extinguisher. It was also observed that the fire extinguishers on the upper level was 1-A:10-BC (size) rated and did not have at least one 2-A:10-B:C rated fire extinguisher as required. During the interview on July 30, 2024, at 11:30 a.m., LALD/CNS-A stated that the resident from the upper level did not allow anyone to come to the level to maintain the fire extinguisher. LALD/CNS-A verified that the required annual inspection had not been completed on the upper-level fire extinguisher and verified that it was not of the appropriate size. TIME PERIOD FOR CORRECTION: Seven (7)	0 790			

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0 790	Continued From page 32 days	0 790			
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On July 30, 2024, at 10:30 a.m., survey staff toured the facility with the licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A. During the facility tour, survey staff observed the following items:	0 800			

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0 800	Continued From page 33 On the patio outside of the exit door to the front yard, it was observed that burnt, used cigarettes were being disposed of without a proper disposal container, creating a possible fire hazard. In the bathroom by the resident sleeping room 5 on the lower level, it was observed the shower tub was cracked, causing water to leak onto the adjacent floor and damaging the floor, wall, and base tile. In the bathroom by resident sleeping 4 on the lower level, it was observed that there were mold or similar black stains on the gypsum ceiling with evidence of water damage. The ceiling finish was bubbled, and the paint was cracked. In resident sleeping room 4, it was observed the door was heavily damaged and had holes. During the interview, LALD/CNS-A stated that one of the residents caused the damage, and the resident in room 4 did not want the facility to replace the door. In resident bedroom 6 on the upper level, it was observed the following items: - It was observed that the multiple plug strips were daisy-chained with an extension cord feeding off one of the plug strips to provide power to the microwave, toaster oven, and refrigerator. The plug strips were attached by multiple electrical equipment, creating a fire hazard. - It was observed there were brown stains on the sheetrock ceiling with evidence of water leakage from above the ceiling. - It was observed there were brown stains on the sheetrock ceiling with evidence of water leakage from above the ceiling. - It was observed there were holes in the gypsum	0 800			

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0 800	Continued From page 34 ceiling. - It was observed the ceiling electrical box was missing cover, and electrical wires were exposed. During the facility tour on July 30, 2024, at 10:30 a.m., LALD/CNS-A visually verified these deficient findings at the time of discovery. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800			
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of 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	0 810			

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0 810	Continued From page 35 least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on the interview and record review, the licensee failed to develop the fire safety and evacuation plan with the required content, failed to provide the required training, and failed to provide the required drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety, 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 July 30, 2023, at 1:00 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A provided documentation on the fire safety and evacuation plan (FSEP), fire safety and evacuation training for the facility, and fire safety and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The FSEP did not show the number of resident rooms, and resident rooms were not identified by	0 810			

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0 810	Continued From page 36 number. TRAINING Record review of the available documentation indicated employees did not receive training twice per year after initial hire. During the interview on July 30, 2024, at 1:30 p.m., LALD/CNS-A stated the licensee provided annual training on the fire safety and evacuation plan to employees, but not twice per year after the initial hire, as required by statute. LALD/CNS-A confirmed there was no further documented training for the staff on the fire safety and evacuation plan as required by statute. DRILLS 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. Records of the fire drill were requested, but no records were provided. During the interview on July 30, 2024, at 1:30 p.m., LALD/CNS-A confirmed that the drills were conducted every six months only and verified there were no further documented drills for the facility. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810			
0 820 SS=G	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	0 820			

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0 820	Continued From page 37 chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure physical facility elements did not constitute a distinct hazard to life. The licensee also failed to provide a resident bedroom with the minimum window opening and door size, meeting the minimum state standard for egress. This affected the occupied resident in bedroom 6 on the upper level and bedroom 4 on the lower level. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On July 30, 2024, at 10:30 a.m., survey staff toured the facility with the licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A. During the facility tour, survey staff observed the following items:	0 820	This immediate correction order identified on July 30, 2024, has had the immediacy lifted as of August 13, 2024, however non-compliance remained a scope and level of G.		

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0 820	Continued From page 38 It was observed that occupied resident bedroom 6 on the upper level did not have a window that met the minimum size requirements for egress escape. The clear openable area of the opened window measured 36 inches in height and 16 inches in width, with a total openable area of 576 square inches. The windows did not meet the minimum requirements for opening height and did not meet the minimum requirements for total openable area. Egress windows in existing sleeping rooms must have a minimum openable width of 20 inches and minimum openable height of 20 inches with no less than 648 square inches total of openable area (4.5 square feet) for the window. Survey staff explained to LALD/CNS-A that at least one egress window in each bedroom must be provided to meet the minimum state standard for an egress window to be a complying bedroom for resident occupancy. LALD/CNS-A verbally confirmed the findings. On July 30, 2024, at 12:00 p.m., during the interview, survey staff explained to LALD/CNS-A that an immediate correction order was issued for the above finding. LALD/CNS-A acknowledged the above finding. During the facility tour at 10:30 a.m. with the licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A, it was also observed that occupied resident bedrooms 4 on the lower level did not have a door that met the minimum size requirements for egress escape. The door height in room 4 on the lower level was 5'-9". During the interview on July 30, 2024, at 11:00 a.m., survey staff explained to LALD/CNS-A that	0 820			

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0 820	Continued From page 39 egress door in existing sleeping rooms must have no less than 6'-6" in height and no less than 2'-0" in width. During the same interview, LALD/CNS-A acknowledged the above finding. No Further information was provided. TIME PERIOD FOR CORRECTION: Immediate	0 820			
01290 SS=F	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure they received a background study (BGS) clearance from NETStudy 2.0 (web-based system use to submit BGS requests to the Department of Human Services (DHS)) in affiliation with the assisted living licensee's health facility identification	01290			

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01290	Continued From page 40 number (HFID) 36867 for four of seven employees (unlicensed personnel (ULP)-B, ULP-D, ULP-E, ULP-F). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee's HFID was 36867. ULP-B ULP-B was hired on May 22, 2022, to provide direct cares to residents. The licensee's Employee Roster/Background Roster (Netstudy) form, created during survey, indicated ULP-B had a NETStudy2.0 BGS completed under HFID 27997. On August 1, 2024, at 8:30 a.m., the surveyor observed NETStudy2.0 with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A which indicated ULP-B had a BGS completed under HFID 27997. ULP-D ULP-D was hired on July 31, 2021, to provide direct cares to residents. The licensee's undated Employee Roster/Background Roster (Netstudy) form, created during survey, indicated ULP-D had a NETStudy2.0 BGS completed under HFID 27997.	01290			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36867	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/02/2024
NAME OF PROVIDER OR SUPPLIER ST JOHN HOME CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 2464 HEMLOCK LANE NORTH PLYMOUTH, MN 55441		
(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
01290	Continued From page 41 On August 1, 2024, at 8:30 a.m., the surveyor observed NETStudy2.0 with LALD/CNS-A which indicated ULP-D had a BGS completed under HFID 27997. ULP-E ULP-E was hired on June 15, 2024, to provide direct cares to residents. The licensee's undated Employee Roster/Background Roster (Netstudy) form, created during survey, indicated ULP-E had a NETStudy2.0 BGS completed under HFID 36029. On August 1, 2024, at 8:30 a.m., the surveyor observed NETStudy2.0 with LALD/CNS-A which indicated ULP-E had a BGS completed under HFID 36029. ULP-F ULP-F was hired on February 9, 2024, to provide direct cares to residents. The licensee's undated Employee Rooster/Background Roster (Netstudy) form, created during survey, indicated ULP-F had a NETStudy2.0 BGS completed under HFID 36029. On August 1, 2024, at 8:30 a.m., the surveyor observed NETStudy2.0 with LALD/CNS-A which indicated ULP-F had a BGS completed under HFID 36029. On August 1, 2024, at 8:40 a.m., the surveyor observed ULP-B attempt to administer R2's medication. R2 refused their medication. On August 1, 2024, at 10:28 a.m., LALD/CNS-A stated only three of their employee's had BGS's	01290			

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01290	Continued From page 42 completed under HFID 36867 but the rest were affiliated with their sister facility HFID's. On August 1, 2024, at 11:25 a.m., LALD/CNS-A stated they were not fully aware of BGS requirements which required staff to be affiliated with each individual HFID of the licensee's they work at. LALD/CNS-A stated they were going to go through NETStudy2.0 rosters as soon as possible to get all of their staff affiliated correctly. LALD/CNS-A was able to demonstrate they had access to HFID 27997 and 36029 on NETStudy2.0 and would receive notifications if staff's eligibility were to change. The licensee's 4.02 Background Studies policy dated October 1, 2021, indicated, "[licensee] will conduct a Minnesota Department of Human Services Background Study on all employees and volunteers and contractors at [licensee]." It further indicated, "No employee may provide direct services and have independent direct contact with any residents until acceptable result of the background study have been received. [Licensee] will not employ individuals whose results of the background study indicate disqualification for the position." No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290			
01820 SS=D	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed	01820			

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01820	Continued From page 43 medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure written or electronically recorded prescriptions were obtained for one of two residents (R4). 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: R4 was admitted to the licensee on January 12, 2021. R4's Service Plan form dated December 11, 2022, indicated R4 received medication services. R4's Medication Administration Record (MAR) for July 2024, indicated R4 took the following medications: -hydrocortisone 2.5%, insert rectally two times a day; -hydroxyzine hydrochloride (HCL) 25mg, take one tablet (25mg) PO every four hours as needed (PRN) for anxiety; -quetiapine fumarate 300 milligrams (mg), take one tablet (300mg) by mouth (PO) at bedtime; -quetiapine fumarate 100mg, take one tablet (100mg) PO at bedtime PRN for insomnia and	01820			

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01820	Continued From page 44 agitation; and -trazodone HCL 50mg, take one tablet (50mg) PO at bedtime PRN. R4's record included a Physician's Order pharmacy form dated October 2023. The medications on the form matched what was on R4's MAR for July 2024. It was signed by licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A on November 1, 2023. It lacked authentication from the prescribers. On August 1, 2024, at 10:50 a.m., LALD/CNS-A stated their signature on the Physician's Order pharmacy form was to acknowledge they reviewed it. LALD/CNS-A stated they had some signed orders for individual medications and would find them. On August 1, 2024, at 12:06 p.m., LALD/CNS- stated they found additional medication lists, but neither was signed. On August 1, 2024, at 1:36 p.m., the surveyor sent an email with a final request for R4's signed orders. On August 2, 2024, at 9:58 a.m., LALD/CNS-A stated if they didn't send an email to the surveyor with R4's orders then they didn't have them. LALD/CNS-A stated they normally get doctors' orders for all medications. LALD/CNS-A stated they had a lot of documents and were searching through them for R4's medication orders. LALD/CNS-A stated they knew they had R4's orders but could not find the orders. LALD/CNS-A stated it was their responsibility to make sure they had signed orders. The licensee's 7.20 Medication & Treatment	01820			

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01820	Continued From page 45 Orders policy dated August 1, 2021, indicated: "1)The RN is responsible for assuring that: a. current, authorized prescriber orders for medications or treatments administered by the staff are kept on file in the residents' records b. communicated to the resident or responsible party c. educate resident or responsible party on all medication and treatment orders, and d. changes in orders are addressed in the resident's service plan and are communicated to the other staff. 2) An order for medication or treatment must contain the name of the resident, a description of the medication, treatment or therapy to be provided and the frequency, duration, and other information needed to carry out the order. 3) An order for medication or treatment must be dated, signed by the prescriber and must be current and consistent with the resident's nursing assessment. 4) Upon receiving verbal orders or unsigned electronic orders, a licensed nurse will record and sign the order and forward the written order to the prescriber for a signature after receipt of the verbal or electronic order. The licensed nurse will continue to follow-up with the prescriber's office until the signature is received. 5) The licensed nurse will communicate with the prescriber to assure that the prescriber renews a medication or treatment/therapy order at least every 12 months, or more frequently as needed. 6) The licensed nurse will review all medication and treatment orders for progress, effectiveness and necessity on a regular basis and with resident change of condition. 7) The license nurse will also monitor and evaluate medication and treatment/therapy orders and services for effectiveness on a regular basis. 8) A residents MAR and TAR will be audited	01820			

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01820	Continued From page 46 regularly by licensed nurse or designee for documentation compliance." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820			
02310 SS=F	144G.91 Subd. 4 (a) Appropriate care and services (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. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medical oxygen tanks were secured stored properly in noncombustible racks to prevent injury to all residents who resided in the assisted living facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an widespread scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On July 30, 2024, at 11:00 a.m., Minnesota	02310			

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02310	Continued From page 47 Department of Health (MDH) environmental engineer surveyor notified the registered nurse (RN) surveyor they observed oxygen storage concerns in room two. On July 31, 2024, at 10:17 a.m., the RN surveyor observed R6's room which included two unsecured full oxygen canisters and one empty oxygen canister in the corner of R6's room behind the bedroom door. The oxygen canisters were leaning upright against the wall and lacked proper storage security. Additionally, there was one empty canister in a two-wheeled oxygen cart used by residents for transporting oxygen while in use. Licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A inquired why the surveyor was observing the oxygen canister storage. The surveyor explained it was due to the oxygen canisters improper storage. LALD/CNS-A inquired what the surveyor meant by improper storage. The surveyor explained the oxygen canisters should be stored in oxygen storage racks or securely chained in place to prevent them from tipping over. LALD/CNS-A stated R6 didn't even use the oxygen anymore and would have them removed from R6's room. LALD/CNS-A inquired where they could obtain proper storage equipment. The surveyor directed them to the oxygen supplier. On August 1, 2024, at 1:31 p.m., R6 stated they no longer used the oxygen but had been in the corner of their room for a while. The Minnesota Department of Health Oxygen Cylinder Storage Requirements dated April 16, 2020, recommends oxygen tanks be secured with racks or by chains. The licensee's 2.40 Oxygen Use & Oxygen	02310			

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02310	Continued From page 48 Saturation Levels policy, undated, indicated, "Can be dangerous if allowed to fall over - if damaged, the cylinder can act as a rocket, causing significant structural damage, potential injuries to person, and explosions." It further indicated, "E-tank cylinders must be secured in a carrier or in some other way (e.g., chained to wall) to prevent falling over." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310			
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 verbatim notice was posted at the facility main entrance to disclose electronic monitoring activity. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all	03090			

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03090	Continued From page 49 the residents). The findings include: On July 29, 2024, at 9:30 a.m., the surveyor observed the exterior of the facility which had one primary entrance. The surveyor observed a small sticker with a camera on it in the window. The entrance lacked signage to notify visitors of the following required verbatim notice, "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." On July 29, 2024, at 11:07 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated they thought the required video monitoring signage was posted at the front entrance. The licensee's 2.15 Electronic Monitoring policy dated October 1, 2021, indicated, "Signs are installed at each facility entrance accessible to visitors that state: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons or activities." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	03090			

Type: Full
Date: 07/29/24
Time: 11:30:00
Report: 1051241063

Food and Beverage Establishment Inspection Report

Page 1

Location:

St John Home Care
2464 Hemlock Lane North
Plymouth, MN55441
Hennepin County, 27

Establishment Info:

ID #: 0038616
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6122453474
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.

3-800 Highly Susceptible Populations

3-801.11B **** Priority 1 ****

MN Rule 4626.0447B Discontinue using unpasteurized eggs or egg products in the preparation of Caesar salad, hollandaise or Bearnaise sauce, mayonnaise, meringue, eggnog, ice cream, and egg-fortified beverages when serving a highly susceptible population.

USE PASTEURIZED EGGS WHEN PREPARING SALADS FOR RESIDENTS.

Comply By: 07/29/24

4-300 Equipment Numbers and Capacities

4-301.12A **** Priority 2 ****

MN Rule 4626.0680A Provide a 3 compartment sink with integrally attached drainboards at each end for manually washing, rinsing and sanitizing equipment and utensils.

UPSTAIRS AND DOWNSTAIRS KITCHEN DOES NOT HAVE 3-COMPARTMENT SINK OR DISHMACHINE. SEE COMMENT SECTION.

Comply By: 08/29/24

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.

AT TIME OF INSPECTION, THERE WAS NO THERMOMETER.

Comply By: 07/29/24

Type: Full
Date: 07/29/24
Time: 11:30:00
Report: 1051241063
St John Home Care

Food and Beverage Establishment Inspection Report

Page 2

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.

NO CFPM. SEND IN A FULL TIME STAFF TO TAKE AN APPROVED TRAINING COURSE. WITHIN 6 MONTHS OF PASSING TRAINING COURSE, SUBMIT RESULTS WITH CFPM INITIAL APPLICATION TO THE STATE.

Comply By: 09/12/24

Food and Equipment Temperatures

Process/Item: Upright Cooler

Temperature: 40 Degrees Fahrenheit - Location: AMBIENT-DOWNSTAIRS KITCHEN

Violation Issued: No

Process/Item: Upright Cooler

Temperature: 36 Degrees Fahrenheit - Location: MILK-UPSTAIRS KITCHEN

Violation Issued: No

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

MET WITH NURSE EVALUATOR, JOEY KEEN.

DISCUSSED THE FOLLOWING WITH THE PERSON IN CHARGE, JOY:

EMPLOYEE ILLNESS LOG (LOG WILL BE SENT WITH REPORT)

REPORTABLE ILLNESSES AND SYMPTOMS

VOMIT CLEAN-UP

CERTIFIED FOOD PROTECTION MANAGER (INITIAL APPLICATION SENT)

HIGHLY SUSCEPTIBLE POPULATION

THE UPSTAIRS AND DOWNSTAIRS KITCHEN DOES NOT HAVE DISHMACHINE OR 3-COMPARTMENT SINK. PROVIDE A DISHMACHINE OR 3-COMPARTMENT SINK. INSTRUCTED THE PERSON IN CHARGE TO SET UP A CONTAINER OF SANITIZER SOLUTION AS A TEMPORARY 3-COMPARTMENT SINK.

BOTH THE UPSTAIRS AND DOWNSTAIRS KITCHEN USES LAMINATE COUNTERTOPS AND FLOORS, MDF WOODEN CABINETS, AND A SMOOTH TEXTURE CEILING.

Type: Full
Date: 07/29/24
Time: 11:30:00
Report: 1051241063
St John Home Care

Food and Beverage Establishment Inspection Report

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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 1051241063 of 07/29/24.

Certified Food Protection Manager: _____

Certification Number: _____ Expires: ____ / ____ / ____

Inspection report reviewed with person in charge and emailed.

Signed: _____

Joy

Signed: _____

Kai Yang
Public Health Sanitarian 1
St. Cloud
320 640-3532
Kai.Yang@state.mn.us