



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

September 3, 2025

Licensee
Roberts House
7749 Newton Avenue North
Brooklyn Park, MN 55444

RE: Project Number(s) SL38061016

Dear Licensee:

On July 22, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on January 31, 2025. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'Tim Hanna'.

Tim Hanna, Supervisor
State Engineering Services Section
Email: Tim.Hanna@state.mn.us
Telephone: 507-208-8982 Fax: 1-866-890-9290

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 38061	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 07/22/2025
NAME OF PROVIDER OR SUPPLIER ROBERTS HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 7749 NEWTON AVENUE NORTH BROOKLYN PARK, MN 55444			
(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 FOLLOW UP SURVEY INITIAL COMMENTS SL38061016-2 On July 22, 2025, 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 April 23, 2025. As a result of the follow-up survey, the licensee is in substantial compliance.	{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.		
{0 470} SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for	{0 470}			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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{0 470}	Continued From page 1 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:	{0 470}			
{0 480} SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626.	{0 480}	Not reviewed during this survey.		

Minnesota Department of Health

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{0 480}	Continued From page 2 (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant	{0 480}			

Minnesota Department of Health
STATE FORM 6899 KMI913 If continuation sheet 4 of 19

Minnesota Department of Health

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{0 500} SS=F	144G.41 Subd. 2 Policies and procedures Each assisted living facility must have policies and procedures in place to address the following and keep them current: (1) requirements in section 626.557, reporting of maltreatment of vulnerable adults; (2) conducting and handling background studies on employees; (3) orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; (4) handling complaints regarding staff or services provided by staff; (5) conducting initial evaluations of residents' needs and the providers' ability to provide those services; (6) conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate; (7) orientation to and implementation of the assisted living bill of rights; (8) infection control practices; (9) reminders for medications, treatments, or exercises, if provided; (10) conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards; (11) ensuring that nurses and licensed health professionals have current and valid licenses to practice; (12) medication and treatment management; (13) delegation of tasks by registered nurses or licensed health professionals; (14) supervision of registered nurses and	{0 500}			

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{0 500}	Continued From page 5 licensed health professionals; and (15) supervision of unlicensed personnel performing delegated tasks. This MN Requirement is not met as evidenced by:	{0 500}	Not reviewed during this survey.		
{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:	{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	{0 640}			

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{0 640}	Continued From page 6 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:	{0 640}	Not reviewed during this survey.		
{0 650} SS=F	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, 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:	{0 650}			

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{0 650}	Continued From page 7	{0 650}	Not reviewed during this survey.		
{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}			
{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	{0 680}	Not reviewed during this survey.		

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{0 680}	Continued From page 8 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:	{0 680}	Not reviewed during this survey.		
{0 800} SS=D	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:	{0 800}			

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{0 810}	Continued From page 9	{0 810}			
{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) staff 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) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff 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:	{0 810}			
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{0 810}	Continued From page 10	{0 810}			
{0 970} SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by:	{0 970}			
{01370} SS=F	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to	{01370}	Not reviewed during this survey.		

Minnesota Department of Health

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{01370}	Continued From page 11 perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by:	{01370}	Not reviewed during this survey.		
{01380} SS=F	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive,	{01380}			

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{01380}	Continued From page 12 and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by:	{01380}	Not reviewed during this survey.		
{01420} SS=F	144G.62 Subd. 2 Delegation of assisted living services (b) When the registered nurse or licensed health professional delegates tasks to unlicensed personnel, that person must ensure that prior to the delegation the unlicensed personnel is trained in the proper methods to perform the tasks or procedures for each resident and is able to demonstrate the ability to competently follow the procedures and perform the tasks. If the unlicensed personnel has not regularly performed the delegated assisted living task for a period of 24 consecutive months, the unlicensed personnel must demonstrate competency in the task to the registered nurse or appropriate licensed health professional. The registered nurse or licensed health professional must document instructions for the delegated tasks in the resident's record. This MN Requirement is not met as evidenced by:	{01420}			
{01500} SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training	{01500}			

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{01500}	Continued From page 13 may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics:	{01500}			

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{01500}	Continued From page 14 (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by:	{01500}	Not reviewed during this survey.		
{01530} SS=F	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De- (a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; (2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5),	{01530}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 38061	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 07/22/2025
NAME OF PROVIDER OR SUPPLIER ROBERTS HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 7749 NEWTON AVENUE NORTH BROOKLYN PARK, MN 55444			
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{01530}	Continued From page 15 and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and the initial two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by:	{01530}	Not reviewed during this survey.		
{01730} SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, a registered nurse, advanced practice registered nurse, or qualified staff delegated the task by a registered nurse must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for	{01730}			

Minnesota Department of Health

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{01730}	Continued From page 16 each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by:	{01730}	Not reviewed during this survey.		

Minnesota Department of Health

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{01750}	Continued From page 17	{01750}	Not reviewed during this survey.		
{01750} SS=F	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by:	{01750}			
{01760} SS=F	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced	{01760}			

Minnesota Department of Health

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{01760}	Continued From page 18 by:	{01760}	Not reviewed during this survey.		
{01880} SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by:	{01880}	Not reviewed during this survey.		
{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:	{02310}	Not reviewed during this survey.		



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

June 3, 2025

Licensee
Roberts House
7749 Newton Avenue North
Brooklyn Park, MN 55444

RE: Project Number(s) SL38061016

Dear Licensee:

On April 23, 2025, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on January 31, 2025. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the January 31, 2025 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on January 31, 2025, found not corrected at the time of the April 23, 2025, follow-up survey and/or subject to penalty assessment are as follows:

0775-Fire Protection And Physical Environment-144g.45 Subd. 2. (a)

The details of the violations noted at the time of this follow-up survey completed on April 23, 2025 (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.

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

DOCUMENTATION OF ACTION TO COMPLY

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

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>

We urge you to review these orders carefully. If you have questions, please contact Jess Schoenecker at 651-201-3789.

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,

A handwritten signature in dark ink, appearing to read 'Jess', with a stylized flourish extending to the right.

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

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 38061	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 04/23/2025
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{0 000}	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER 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: SL#38061016-1 On April 23, 2025, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on January 31, 2025. At the time of the survey, there were 2 active residents; 2 receiving services under the Assisted Living license. As a result of the revisit, the following orders were reissued and/or issued.	{0 000}	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. 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.		
{0 470} SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for	{0 470}			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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{0 470}	Continued From page 1 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:	{0 470}			
{0 480} SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626.	{0 480}	Not reviewed during this survey.		

Minnesota Department of Health

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{0 480}	Continued From page 2 (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant	{0 480}			

Minnesota Department of Health

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{0 480}	Continued From page 3 lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by:	{0 480}	Not reviewed during this survey.		
{0 485} SS=C	144G.41 Subdivision 1.a (a) Minimum requirements; required food services All assisted living facilities must offer to provide or make available at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes. The facility must not require a resident to include and pay for meals in the resident's contract. This MN Requirement is not met as evidenced by:	{0 485}			
{0 500} SS=F	144G.41 Subd. 2 Policies and procedures	{0 500}	Not reviewed during this survey.		

Minnesota Department of Health

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{0 500}	Continued From page 4 Each assisted living facility must have policies and procedures in place to address the following and keep them current: (1) requirements in section 626.557, reporting of maltreatment of vulnerable adults; (2) conducting and handling background studies on employees; (3) orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; (4) handling complaints regarding staff or services provided by staff; (5) conducting initial evaluations of residents' needs and the providers' ability to provide those services; (6) conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate; (7) orientation to and implementation of the assisted living bill of rights; (8) infection control practices; (9) reminders for medications, treatments, or exercises, if provided; (10) conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards; (11) ensuring that nurses and licensed health professionals have current and valid licenses to practice; (12) medication and treatment management; (13) delegation of tasks by registered nurses or licensed health professionals; (14) supervision of registered nurses and	{0 500}			

Minnesota Department of Health

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{0 500}	Continued From page 5 licensed health professionals; and (15) supervision of unlicensed personnel performing delegated tasks. This MN Requirement is not met as evidenced by:	{0 500}	Not reviewed during this survey.		
{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:	{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	{0 640}			

Minnesota Department of Health

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{0 640}	Continued From page 6 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:	{0 640}	Not reviewed during this survey.		
{0 650} SS=F	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, 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:	{0 650}			

Minnesota Department of Health

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{0 650}	Continued From page 7	{0 650}	Not reviewed during this survey.		
{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}			
{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	{0 680}	Not reviewed during this survey.		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 38061	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 04/23/2025
NAME OF PROVIDER OR SUPPLIER ROBERTS HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 7749 NEWTON AVENUE NORTH BROOKLYN PARK, MN 55444			
(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
{0 680}	Continued From page 8 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:	{0 680}	Not reviewed during this survey.		
{0 775} SS=D	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure physical facility elements did not constitute a distinct hazard to life. The licensee failed to provide resident bedrooms with the minimum window opening meeting the minimum state standard for egress. 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	{0 775}			

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{0 775}	Continued From page 9 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: On April 23, 2025, surveyor conducted a revisit to follow-up on orders issued pursuant to a follow up survey completed on January 31, 2025. On April 23, 2025, at 9:10 a.m., per phone conversation, licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated the window in bedroom 3 was replaced. On April 23, 2025, at 10:10 a.m., surveyor toured the facility with LALD/CNS-C. During the tour, surveyor asked LALD/CNS-C to open the recent window in resident bedroom 3, for measurement. The window for occupied bedroom 3 was unable to be measured as the window attached on the hardware side of the window frame when attempted to open and would not open. The window in bedroom 3 did not meet the minimum requirements for clear width, clear height, and total openable area. On April 23, 2025, at 10:20 a.m., LALD/CNS-C stated was unaware that bedroom 3's window was not installed properly and would not open. LALD/CNS-C also stated licensee would contact the window installer to have the window fixed. Surveyor explained to LALD/CNS-C that at least one window in each bedroom in a state-licensed facility must meet the minimum state fire code	{0 775}			

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{0 775}	Continued From page 10 standard for an egress window to be a complying bedroom for resident occupancy. LALD/CNS-C verbally confirmed the findings. Egress windows in existing sleeping rooms must have a minimum openable width of 20 inches and minimum openable height of 20 inches with no less than 648 square inches total of openable area (4.5 square feet) for the window. No further information was provided.	{0 775}			
{0 800} SS=D	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:	{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) staff actions to be taken in the event of a fire or similar emergency;	{0 810}	Not reviewed during this survey.		

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{0 810}	Continued From page 11 (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) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff 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:	{0 810}			
{0 970} SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a	{0 970}	Not reviewed during this survey.		

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{0 970}	Continued From page 12 lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by:	{0 970}	Not reviewed during this survey.		
{01370} SS=F	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences,	{01370}			

Minnesota Department of Health

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{01370}	Continued From page 13 cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by:	{01370}	Not reviewed during this survey.		
{01380} SS=F	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by:	{01380}			

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{01420}	Continued From page 14	{01420}			
{01420} SS=F	144G.62 Subd. 2 Delegation of assisted living services (b) When the registered nurse or licensed health professional delegates tasks to unlicensed personnel, that person must ensure that prior to the delegation the unlicensed personnel is trained in the proper methods to perform the tasks or procedures for each resident and is able to demonstrate the ability to competently follow the procedures and perform the tasks. If the unlicensed personnel has not regularly performed the delegated assisted living task for a period of 24 consecutive months, the unlicensed personnel must demonstrate competency in the task to the registered nurse or appropriate licensed health professional. The registered nurse or licensed health professional must document instructions for the delegated tasks in the resident's record. This MN Requirement is not met as evidenced by:	{01420}			
{01500} SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in	{01500}	Not reviewed during this survey.		

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{01500}	Continued From page 15 the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies,	{01500}			

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{01500}	Continued From page 16 assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by:	{01500}	Not reviewed during this survey.		
{01530} SS=F	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced	{01530}			

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{01530}	Continued From page 17	{01530}	Not reviewed during this survey.		
{01730} SS=F	by: 144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions.	{01730}			

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{01730}	Continued From page 18 (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by:	{01730}	Not reviewed during this survey.		
{01750} SS=F	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by:	{01750}			
{01760} SS=F	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who	{01760}			

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{01760}	Continued From page 19 administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by:	{01760}	Not reviewed during this survey.		
{01880} SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by:	{01880}			
{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:	{02310}			

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Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

April 2, 2025

Licensee
Roberts House
7749 Newton Avenue North
Brooklyn Park, MN 55444

RE: Project Number(s) SL38061016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on January 31, 2025, 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.

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

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

0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - \$3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$3,500.00.** 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 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.

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 dark ink, appearing to read 'Jess', with a stylized flourish extending to the right.

Jess Schoenecker, Supervisor

State Evaluation Team

Email: jess.schoenecker@state.mn.us

Telephone: 651-201-3789 Fax: 1-866-890-9290

JMD

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 38061	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/31/2025
NAME OF PROVIDER OR SUPPLIER ROBERTS HOUSE			STREET ADDRESS, CITY, STATE, ZIP CODE 7749 NEWTON AVENUE NORTH BROOKLYN PARK, MN 55444		
(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 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: SL38061016-0 On January 27, 2025, through January 31, 2025 the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were three residents receiving services under the Assisted Living Facility license. An immediate correction order was identified on January 28, 2025, issued for SL38061016-0, tag identification 0775.	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.		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for	0 470			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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0 470	Continued From page 1 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 the required 24-hour staffing schedule was posted in a central location. 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	0 470			

Minnesota Department of Health

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0 470	Continued From page 2 cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On January 27, 2025, at 11:12 a.m., during the facility tour, the surveyor did not observe a 24-hour staffing schedule posted. On January 27, 2025, at 11:34 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated the schedule had been taken down as the licensee updated the schedule on Mondays. The licensee's Items to be Posted in Assisted Living Residences policy dated 2022, indicated a daily staffing schedule would be posted in a public area. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 470			
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a	0 480			

Minnesota Department of Health

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0 480	Continued From page 3 certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and	0 480			

Minnesota Department of Health

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0 480	Continued From page 4 (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated January 27, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480			
0 485 SS=C	144G.41 Subdivision 1.a (a) Minimum requirements; required food services All assisted living facilities must offer to provide or make available at least three nutritious meals daily with snacks available seven days per week,	0 485			

Minnesota Department of Health

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0 485	Continued From page 5 according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes. The facility must not require a resident to include and pay for meals in the resident's contract. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not require any resident to include and pay for meals as a part of their assisted living monthly base fee for two of two residents (R2, R3). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: R2 R2 was admitted to licensee on December 22, 2023, with diagnoses of congestive heart failure (progressive heart disease that affects pumping action of the heart muscles) and diabetes.	0 485			

Minnesota Department of Health

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0 485	Continued From page 6 R2's Assisted Living Contract dated December 22, 2023, indicated three meals per day were included in the basic monthly fee. R3 R3 was admitted to licensee on November 8, 2024, with a diagnosis of pressure ulcers. R3's Assisted Living Contract dated November 8, 2024, indicated three meals per day were included in the basic monthly fee. On January 29, 2025, at 2:50 p.m., LALD/CNS-C stated they would contact a consultant to have the contract changed. LALD/CNS-C stated it may have been mentioned at other surveys for different facilities that the monthly base fee could not include meals. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485			
0 500 SS=F	144G.41 Subd. 2 Policies and procedures Each assisted living facility must have policies and procedures in place to address the following and keep them current: (1) requirements in section 626.557, reporting of maltreatment of vulnerable adults; (2) conducting and handling background studies on employees; (3) orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; (4) handling complaints regarding staff or services provided by staff; (5) conducting initial evaluations of residents'	0 500			

Minnesota Department of Health

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0 500	Continued From page 7 needs and the providers' ability to provide those services; (6) conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate; (7) orientation to and implementation of the assisted living bill of rights; (8) infection control practices; (9) reminders for medications, treatments, or exercises, if provided; (10) conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards; (11) ensuring that nurses and licensed health professionals have current and valid licenses to practice; (12) medication and treatment management; (13) delegation of tasks by registered nurses or licensed health professionals; (14) supervision of registered nurses and licensed health professionals; and (15) supervision of unlicensed personnel performing delegated tasks. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and/or implement policies and procedures as required. 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	0 500			

Minnesota Department of Health

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0 500	Continued From page 8 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: During the entrance conference on January 27,2025, at 10:10 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated the licensee's employees in charge of the facility were familiar with the assisted living regulations and the licensee provided medication and treatment management services. The licensee's Application for Assisted Living License, section titled Official Verification of Owner or Authorized Agent, (page four and five of the application), identified, I certify I have read and understand the following: [a check mark was placed before each of the following]: - I attest to have all required policies and procedures of Minn. Stat. chapter 144G and Minn. Rules chapter 4659 in place upon licensure and to keep them current as applicable. Page five was electronically signed by LALD/CNS-C on November 4, 2023. The licensee had an assisted living license issued on February 9, 2024, with an expiration date of February 8, 2025. The licensee failed to ensure the following policies and procedures were developed and/or implemented: - requirements in section 626.557, reporting of maltreatment of vulnerable adults;	0 500			

Minnesota Department of Health

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0 500	Continued From page 9 - orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; - infection control practices; - reminders for medications, treatments, or exercises, if provided; - conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards; - medication and treatment management; - delegation of tasks by registered nurses or licensed health professionals; On January 27, 2025, at 10:00 a.m., LALD/CNS-C confirmed the licensee provided assisted living services but failed to implement corresponding policies and procedures, as required. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 500			
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.	0 510			

Minnesota Department of Health

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0 510	Continued From page 10 (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 complies with accepted health care, medical and nursing standards for infection control related to handwashing, glove use, and proper technique for disposal of used needles for one of one unlicensed personnel ((ULP)-B). The deficient practice had the potential to affect 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) 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: HAND HYGIENE AND GLOVE USE ULP-B's OSHA and Infection Control skill competency dated November 10, 2024, indicated ULP-B had demonstrated competency and passed on handwashing with the registered nurse (RN). On January 28, 2025, at 8:10 a.m., during continuous medication observation with ULP-B for R3 and R2, the surveyor observed ULP-B perform hand hygiene with hand sanitizer and donned (put on) gloves. ULP-B proceeded to touch a variety of surfaces in the common area of	0 510			

Minnesota Department of Health

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0 510	Continued From page 11 the facility that included the computer, medication closet, red medication cart, narcotic count book, a rolling cart with vital sign equipment and a large jar full of juice used for all residents. ULP-B went into R3's room where they performed checking R3's vital signs (blood pressure, oxygen saturation, and temperature) and administered R3's oral medications. ULP-B did not remove gloves or perform hand hygiene after provided cares to R3. After provided cares to R3, ULP-B proceeded to touch a variety of surfaces again in the common area of the facility that included the computer, inside of the facility refrigerator used for food and medications, medication closet, R2's glucometer (used to check blood for blood glucose), rolling cart, kitchen cupboard to retrieve a clean glass, and kitchen facet. ULP-B then went into R2's room still wearing the same gloves where they performed checking R2's vital signs (blood pressure, oxygen saturation and temperature), administered R2's oral medications, poked R2's finger to check blood glucose, administered insulin into R2's abdomen, and placed a topical patch on R2's back. ULP-B did not remove gloves or perform hand hygiene after provided cares to R2. After provided cares to R2, ULP-B proceeded to touch a variety of surfaces again in the common area of the facility that included the medication closet, sharps container, rolling cart, and vital sign equipment. ULP-B removed the gloves and did not perform hand hygiene afterwards. On January 28, 2025, at 11:07 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated the expectations were for staff to wear gloves period and the gloves were to be donned before providing care on each patient and then doffed (take off) after the cares were provided in the resident room; and then for staff	0 510			

Minnesota Department of Health

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0 510	Continued From page 12 to wash their hands after removing the gloves. LALD/CNS-C stated the licensee had discussed putting hand sanitizers outside of the resident rooms in the hallway. Also, LALD/CNS-C stated all staff were trained on handwashing and donning/doffing personal protective equipment as well. On January 29, 2025, at 12:43 a.m., the surveyor observed ULP-B wearing gloves walking through the living room. LALD/CNS-C asked ULP-B why they were wearing gloves and stated those need to be taken off in the room after cares. RECAPPING NEEDLES ULP-B's undated Medication and Treatment - Insulin Administration skill competency indicated ULP-B had demonstrated competency and passed on insulin administration that included donning/doffing gloves before and after the procedure, disposal of needles into sharps container, and instruction to never recap the needle by the RN. On January 28, 2025, at 8:51 a.m., during medication observation, the surveyor observed ULP-B perform insulin administration to R2. Following the insulin administration, the surveyor observed ULP-B recapping two different insulin pen needles with their gloved hands and then removing the recapped needles from the pens and placed the recapped needles on the rolling cart due to not having a sharp's container at the time of administration of the insulin. On January 28, 2025, at 11:06 a.m., LALD/CNS-C stated the insulin pens do not have a system to auto release the needles, so the staff must recap the needles to twist off. After the surveyor further discussed concerns with	0 510			

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER ROBERTS HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 7749 NEWTON AVENUE NORTH BROOKLYN PARK, MN 55444			
(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
0 510	Continued From page 13 recapping needles, LALD/CNS-C stated the staff could use the one hand method to recap the needle and then dispose of the needle in the sharp's container. LALD/CNS-C stated they expected staff to bring the sharps container in the rooms, so the staff did not have to travel with the needles. LALD/CNS-C stated the licensee had bought a rolling cart specifically for this reason so staff could bring all items needed in the room and then stated they needed to do more training. The licensee's Infection Control policy dated April 16, 2022, indicated the licensee would observe the recommended precautions for assisted living as identified by the CDC. The policy indicated hands were to be washed if contaminated with blood or body fluid, immediately after gloves were removed, between resident contacts, and when indicated to prevent transfer of microorganisms between resident or the environment. Also, the policy indicated all sharp instruments and needles were to be discarded in a puncture-resistant container. The CDC recommends needles to be disposed of without capping or that a mechanical device be used for recapping. The Centers for Disease Control and Prevention (CDC) 2007 Guideline for Isolation Precautions: Preventing Transmission of Infections Agents in Healthcare Settings updated September 2024, on page 129, table 4, indicated recommendations for application of standard precautions for the care of all patients in all healthcare settings included the following: - Hand hygiene recommendations after touching blood, body fluids, secretions, excretions, contaminated items, immediately after removing gloves, and between patient contacts; - Personal protective equipment (PPE) gloves recommendations for touching blood, body fluids,	0 510			

Minnesota Department of Health

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0 510	Continued From page 14 secretions, excretions, contaminated items, for touching mucous membranes, and nonintact skin; and -Needles and other sharps recommendations to not recap, bend, break, or hand-manipulate used needles; if recapping would be required, use a one-handed scoop technique only; place used sharps in puncture-resistant container. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) 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, interview, and record review, the licensee failed to support protection and safety by not posting information for reporting to Minnesota Adult Abuse Reporting Center (MAARC); and failed to post the 911 emergency number in common areas and near telephones	0 640			

Minnesota Department of Health

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0 640	Continued From page 15 provided by the assisted living facility. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On January 27, 2025, at 11:12 a.m., during the facility tour, the surveyor did not observe information posted for reporting crime and suspected maltreatment to MAARC or 911 emergency number posted in a common area or by the facility phone. On January 27, 2025, at 11:37 a.m., Licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C had confirmed the facility phone was in the living room above the television and there was no posting for 911 emergency number. On January 27, 2025, at 11:51 a.m., LALD/CNS-C stated the licensee had a 911 poster posted by the telephone. The surveyor observed LALD/CNS-C going over by the television and looking behind the television stand but did not find a posting. LALD/CNS-C had asked staff if they had known where the 911 poster went; staff stated they were sure if had fallen off. On January 27, 2025, at 11:54 a.m., the surveyor	0 640			

Minnesota Department of Health

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0 640	Continued From page 16 observed LALD/CNS-C looking up postings for 911 emergency number on the licensee's computer. The licensee's Items to be Posted in Assisted Living Residences policy dated 2022, indicated 911 emergency number would be posted in common areas and near telephones. The policy did not indicate required posting for information for reporting to Minnesota Adult Abuse Reporting Center (MAARC). No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 640			
0 650 SS=F	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, 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	0 650			

Minnesota Department of Health

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0 650	Continued From page 17 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 personnel records included all the required content for two of two unlicensed personnel ((ULP)-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, 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: ULP-A ULP-A was hired on October 7, 2024, to provide direct care to the residents. ULP-A's personnel record lacked: -the date skill competencies were completed by the registered nurse (RN); -training and competency evaluation for unplanned times away; and -documentation of supervision by the RN within 30 days of performing delegated tasks. On January 31, 2025, at 10:53 a.m., ULP-A stated they had begun their training on October 3, 2024, and the training lasted over a month. ULP-A stated they were always with another staff	0 650			

Minnesota Department of Health

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0 650	Continued From page 18 and licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C was always on site as well. ULP-A stated LALD/CNS-C had observed them providing medications to be sent away with a resident. ULP-B ULP-B was hired on November 10, 2021, to provide direct care to the residents. On January 28, 2025, at 8:10 a.m., the surveyor observed ULP-B assist R3 with medication administration. On January 28, 2025, at 8:51 a.m., the surveyor observed ULP-B assist R2 with medication administration. ULP-B's personnel record lacked documentation of training and competency evaluation for unplanned times away. On January 28, 2025, at 9:40 a.m., ULP-B stated they were trained with Educare (popular online education program) and then they had hands-on training with another staff. ULP-B stated the nurse had observed them doing different tasks. Also, ULP-B stated they also had monthly trainings as well by LALD/CNS-C. On January 29, 2025, at 2:23 p.m., LALD/CNS-C provided to the surveyor, the licensee's written process for the unplanned times away created by LALD/CNS-C. LALD/CNS-C stated they had done training on the process and observed each employee packing up medications but just did not document the competency for the personnel records. On January 29, 2025, at 3:31 p.m., LALD/CNS-C	0 650			

Minnesota Department of Health

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0 650	Continued From page 19 stated it was an oversight for not documenting the dates the competencies were completed and going forward they would make sure the competencies were dated going forward. On January 31, 2025, at 11:29 a.m., LALD/CNS-C stated the 30-day supervision for ULP-A would have been filled out but it just did not make it in the personnel record. LALD/CNS-C stated they take a folder with them when visiting the facilities and believed this may have been an oversight as to why this did not get in the personnel records. The licensee's Personnel Records policy dated April 16, 2022, indicated all documents related to competency evaluations and supervision would be kept in the personnel record. Minnesota Administrative Rule 4659.0190, subpart 6 dated August 11, 2021, indicated a facility must maintain a record for each training and competency evaluation that included the following: -facility name, location, and license number; -name of the training topic or training program, and the training methodology, such as classroom style, web-based training, video, or one-to-one training; -date of the training and competency evaluation, and the total amount of time of the training and competency evaluation; -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 -name and title of the staff person completing the	0 650			

Minnesota Department of Health

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0 650	Continued From page 20 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. No further information 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 the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the 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), to include an updated facility TB risk assessment and a two-step tuberculin skin test (TST) or other	0 660			

Minnesota Department of Health

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0 660	Continued From page 21 evidence of TB screening such as a blood test for one of two unlicensed personnel ((ULP)-A). This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: FACILITY TB RISK ASSESSMENT The licensee's Facility TB Risk Assessment dated January 2, 2025, identified the facility was at a low risk for TB transmission. The form indicated the document would be updated annually to reflect current TB case rates and numbers. The data used to complete the Facility's TB Risk Assessment determine the incidence of TB for the national case rate, Minnesota's case rate, and cases of active TB disease by county included information from the year of 2020 and was not the most recent data for incidences of TB. BASELINE SCREENING ULP-A was hired on October 7, 2024, to provide direct care to the residents. ULP-A's Consent and Release for TB Screening dated October 3, 2024, indicated ULP-A completed history and symptom screening. ULP-A's U.S. Department of State Tuberculosis Worksheet dated July 1, 2024, indicated ULP-A	0 660			

Minnesota Department of Health

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0 660	Continued From page 22 had a chest x-ray completed on July 1, 2024. ULP-A's personnel record lacked: -documentation of TB testing within 90 days of hire; -chest x-ray completed after a positive TB test. On January 29, 2025, at 3:27 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated there was some confusion with the screening process with having a chest Xray within the past five years. The licensee's Tuberculosis Screening/Prevention policy dated April 16, 2022, indicated baseline testing would be completed at hire for all direct care providers; and employees with a verbal, but undocumented history of a previous positive TST or IGRA would undergo the same screening process as those without previous positive results. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660			
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently;	0 680			

Minnesota Department of Health

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0 680	Continued From page 23 (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 interview and record review, the licensee failed to develop a written emergency preparedness (EP) plan with all the required content as defined in Appendix Z. 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) 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: The licensee's undated EP lacked evidence of the following required content: - develop and maintain the EP; - maintain and annual EP updates;	0 680			

Minnesota Department of Health

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0 680	Continued From page 24 - subsistence needs for staff and patients; - procedures for tracking of staff and patients; - policies and procedures for medical documents; - policies and procedures for volunteers; - arrangement with other facilities; - development of communication plan; - names and contact information; - emergency officials contact information; - methods for sharing information; and - sharing information on occupancy/needs. On January 27, 2025, at 1:01 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated they thought the EP was very beneficial and felt they needed to look further into the missing items, especially the emergency supplies, after discussing the Appendix Z requirements with the surveyor. The licensee's Emergency Preparedness policy dated April 16, 2022, indicated the licensee would have a plan in place to assure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupted services. The policy referenced CMS State Operations Manual Appendix Z and MN Rules 4659.0100. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			
0 775 SS=G	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and:	0 775			

Minnesota Department of Health

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0 775	Continued From page 25 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide egress windows in compliance with the Minnesota State Fire Code under Minnesota Rules, chapter 7511. This had the potential to directly affect all residents, staff, and visitors. 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 January 28, 2025, from 1:00 p.m. to 2:00 p.m., the surveyor toured the facility with unlicensed personnel (ULP)-B. During the tour, the surveyor asked ULP-B to open the windows in the resident bedrooms for measurement. The noncompliant measurements were as follows: OCCUPIED SLEEPING ROOMS: Bedroom 3: One windows measuring 39 inches clear width, 16 1/2 inches clear height, and 643 1/2 square inches total open area for each window. The windows in bedroom 3 did not meet the minimum requirements for opening height and did not meet the minimum requirements for total openable area. This deficiency was visually verified by ULP-B at the time of discovery.	0 775			

Minnesota Department of Health

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0 775	Continued From page 26 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. At least one window in each bedroom in a state-licensed facility must meet the minimum state fire code standard for an egress window to be a complying bedroom for resident occupancy. On January 28, 2025, the surveyor explained to licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C that an immediate correction order was issued for the above findings. LALD/CNS-C stated they would get the window replaced as quickly as possible. TIME PERIOD FOR CORRECTION: Immediate. On the same facility tour on January 28, 2025, from 1:00 p.m. to 2:00 p.m., the surveyor observed the exit door out of the basement and the main exit door out of the facility had child locks installed that prevented the door lever from functioning under normal operation. The additional locks were not equipped to automatically release up activation of the building fire alarm system and required additional effort and knowledge to open. The additional locks do not comply with conditions of Minnesota State Fire Code and are not an approved locking method. LALD/CNS-C demonstrated the operation of the lock and confirmed the lock operation required special knowledge and effort. TIME PERIOD FOR CORRECTION: Two (2) days	0 775			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 38061	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/31/2025
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(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
0 800 SS=D	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. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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 January 28, 2025, from 1:00 p.m. to 2:00 p.m., the surveyor toured the facility with unlicensed personnel (ULP)-B. In basement bedrooms 4 and 5 there was significant black staining on the window sills of each window. The window sill in bedroom 4 had standing water on the sill and the black staining on the sill was also	0 800			

Minnesota Department of Health

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0 800	Continued From page 28 on both sides of the window opening. Water penetration and standing water can lead to water damage and potential mold. On January 28, 2025, at 2:00 p.m., ULP-B stated they did not know about the black staining on the windows. 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) staff 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) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year.	0 810			

Minnesota Department of Health

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0 810	Continued From page 29 (f) Evacuation drills are required for staff 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 observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content, to provide the required training, and to conduct evacuation drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On January 28, 2025, from 1:00 p.m. to 2:00 p.m., the surveyor observed the fire evacuation diagrams did not include the location and number of resident rooms. Bedroom 3 was identified as the dining room on the fire evacuation diagrams. Exit plan diagrams must be correctly labeled to reduce confusion and potential obstructions to egress in a fire or similar emergency. On January 28, 2025, licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C provided documents on the fire safety and	0 810			

Minnesota Department of Health

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0 810	Continued From page 30 evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN: The licensee's FSEP, titled "Fire Safety", dated April 16, 2022, failed to include the following: The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The provided FSEP was from a third-party provider and had not been updated to the specific facility. The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. The FSEP included standard resident evacuation procedures but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan included instructions to evacuate residents but did not include any procedures for assisting residents during evacuation nor did it include instructions for staff to follow in case of relocation. On January 28, 2025, at 2:30 p.m., LALD/CNS-C stated their policy was incomplete and licensee would bring them into compliance. TRAINING: The licensee failed to provide evacuation training to residents at least once per year. LALD/CNS-C	0 810			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 38061	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/31/2025
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0 810	Continued From page 31 lacked documentation showing any training was offered or training was scheduled for a future date for residents on the fire safety and evacuation plan. On January 28, 2025, at 1:30 p.m., LALD/CNS-C verified the staff were to receive training upon hire and twice per year. LALD/CNS-C confirmed the facility had not completed training in accordance with their policy. DRILLS: The licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month. Record review of licensee's evacuation drill log, titled "Fire Drill Log", undated, indicated evacuation drills were conducted on May 5, 2023, November 3, 2023, May 3, 2024, and November 1, 2024. No other documentation was provided. On January 28, 2025, at 1:30 p.m., LALD/CNS-C stated there were no additional documented drills for the facility. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810			
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law.	0 970			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 38061	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/31/2025
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0 970	Continued From page 32 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language that waived the licensee's liability for the health, safety, or personal property of a resident for two of two residents (R2, R3). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: R2 R2 was admitted to licensee on December 22, 2023, with diagnoses of congested heart failure (progressive heart disease that affects pumping action of the heart muscles) and diabetes. R2's Assisted Living Contract dated December 22, 2023, read under section Indemnification, "[Licensee] shall not be liable for any damage or injury to the resident ... or to any property, occurring on the premises, or any part thereof, or in common areas thereof, and the resident agrees to hold [licensee] harmless from any claims or damages unless caused solely by negligence of [licensee]." R3 R3 was admitted to licensee on November 8, 2024, with diagnosis of pressure ulcers.	0 970			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 38061	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/31/2025
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0 970	Continued From page 33 R3's Assisted Living Contract dated November 8, 2024, read under section Indemnification, "[Licensee] shall not be liable for any damage or injury to the resident ... or to any property, occurring on the premises, or any part thereof, or in common areas thereof, and the resident agrees to hold [licensee] harmless from any claims or damages unless caused solely by negligence of [licensee]." On January 29, 2025, at 3:17 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated they were not aware the licensee could not have a waiver of liability in the contract; and they would contact a consultant to get this changed. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970			
01370 SS=F	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing;	01370			

Minnesota Department of Health

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01370	Continued From page 34 (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and/or competencies were completed and documented for two of two unlicensed personnel ((ULP)-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, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when	01370			

Minnesota Department of Health

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01370	Continued From page 35 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: ULP-A ULP-A was hired on October 7, 2024, to provide direct care to the residents. On January 29, 2025, at 9:47 a.m., the surveyor verified ULP-A was not listed on the Minnesota Nurse Aide Registry as a current Certified Nursing Assistant. ULP-A's personnel record lacked evidence of completed training and/or competency testing for the following topics as required: - documentation requirements for all services provided; - reports of changes in the resident's condition to the supervisor designated by the assisted living provider; - maintenance of a clean and safe environment; - training on the prevention of falls for providers working with the elderly or individuals at risk of falls; - standby assistance techniques and how to perform them; - medication, exercise, and treatment reminders; - basic nutrition, meal preparation, food safety, and assistance with eating; - preparation of modified diets as ordered by a licensed health professional; - understanding appropriate boundaries between staff and residents and the resident's family; and - procedure to utilize in handling various emergency situations. ULP-B	01370			

Minnesota Department of Health

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01370	Continued From page 36 ULP-B was hired on November 10, 2021, to provide direct care to the residents. On January 28, 2025, at 8:10 a.m., the surveyor observed ULP-B assist R3 with medication administration. On January 28, 2025, at 8:51 a.m., the surveyor observed ULP-B assist R2 with medication administration. On January 29, 2025, at 12:46 p.m., the surveyor verified ULP-B was not listed on the Minnesota Nurse Aide Registry as a current Certified Nursing Assistant. ULP-B's personnel record lacked evidence of completed training and/or competency testing for the following topics as required: - documentation requirements for all services provided; - reports of changes in the resident's condition to the supervisor designated by the assisted living provider; - basic infection control, including blood-borne pathogens; - maintenance of a clean and safe environment; - training on the prevention of falls for providers working with the elderly or individuals at risk of falls; - standby assistance techniques and how to perform them; and - exercise, and treatment reminders. On January 29, 2025, at 1:18 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated they usually would go through Educare (common education program online) to check for completed assigned courses but would get a process in place to ensure follow	01370			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 38061	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/31/2025
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01370	Continued From page 37 up for verifying the completed courses as assigned. The licensee's Staff Competency policy dated April 16, 2022, indicated training and competency evaluations for all ULP's would include the required topics; and ULP's would not work until they had successfully passed the written and demonstrated competency evaluation for the required topics. The policy listed all the required training and competencies topics needed per Statute. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370			
01380 SS=F	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required.	01380			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 38061	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/31/2025
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01380	Continued From page 38 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and/or competencies were completed and documented for two of two unlicensed personnel ((ULP)-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, 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: ULP-A ULP-A was hired on October 7, 2024, to provide direct care to the residents. On January 29, 2025, at 9:47 a.m., the surveyor verified ULP-A was not listed on the Minnesota Nurse Aide Registry as a current Certified Nursing Assistant. ULP-A's personnel record lacked evidence of completed training and/or competency testing for the following topics as required: - basic knowledge of body functioning and changes in the body functioning, injuries, or other observed changes that must be reported to appropriate personnel; - reading and recording temperature, pulse, and respirations of the resident; - recognizing physical, emotional, cognitive, and developmental needs of the resident; and	01380			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 38061	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/31/2025
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01380	Continued From page 39 - range of motioning and positioning. ULP-B ULP-B was hired on November 10, 2021, to provide direct care to the residents. On January 28, 2025, at 8:10 a.m., the surveyor observed ULP-B assist R3 with medication administration. On January 28, 2025, at 8:51 a.m., the surveyor observed ULP-B assist R2 with medication administration. On January 29, 2025, at 12:46 p.m., the surveyor verified ULP-B was not listed on the Minnesota Nurse Aide Registry as a current Certified Nursing Assistant. ULP-B's personnel record lacked evidence of completed training and/or competency testing for the following topics as required: -observation, reporting, and documenting of resident status; - reading and recording temperature, pulse, and respirations of the resident; and - range of motioning and positioning. On January 29, 2025, at 1:18 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated they usually would go through Educare (common education program online) to check for completed assigned courses but would get a process in place to ensure follow up for verifying the completed courses as assigned. The licensee's Staff Competency policy dated April 16, 2022, indicated training and competency evaluations for all ULP's would include the	01380			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 38061	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/31/2025
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01380	Continued From page 40 required topics; and ULP's would not work until they had successfully passed the written and demonstrated competency evaluation for the required topics. The policy listed all the required training and competencies topics needed per Statute. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380			
01420 SS=F	144G.62 Subd. 2 Delegation of assisted living services (b) When the registered nurse or licensed health professional delegates tasks to unlicensed personnel, that person must ensure that prior to the delegation the unlicensed personnel is trained in the proper methods to perform the tasks or procedures for each resident and is able to demonstrate the ability to competently follow the procedures and perform the tasks. If the unlicensed personnel has not regularly performed the delegated assisted living task for a period of 24 consecutive months, the unlicensed personnel must demonstrate competency in the task to the registered nurse or appropriate licensed health professional. The registered nurse or licensed health professional must document instructions for the delegated tasks in the resident's record. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted training and competency evaluations for two of two unlicensed personnel ((ULP)-A, ULP-B) who performed	01420			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 38061	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/31/2025
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01420	Continued From page 41 delegated tasks. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On January 28, 2025, at 8:10 a.m., during a medication observation, the surveyor observed ULP-B check resident (R3's) oxygen saturation (O2 sat) with an oximeter. R3's O2 sat was noted to be at 98%. On January 28, 2025, at 8:51 a.m., during a medication observation, the surveyor observed ULP-B check R2's O2 sat with an oximeter. R2's O2 sat was noted to range from 82% to 92%. ULP-B stated R2's O2 sats were always in the low 80's until R2 woke up, sat up, and has gone outside to have a cigarette, then the O2 sat would go up. ULP-A ULP-A was hired on October 7, 2024, to provide direct care to the residents. ULP-A's personnel record lacked a skill competency for monitoring oxygen saturations. ULP-B ULP-B was hired on November 10, 2021, to provide direct care to the residents.	01420			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 38061	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/31/2025
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01420	Continued From page 42 ULP-B's personnel record lacked a skill competency for monitoring oxygen saturations. On January 28, 2025, at 10:30 a.m., ULP-B stated they had not reported anything to the nurse yet for R2 and they had planned to recheck R2's O2 sat again. On January 28, 2025, at 10:35 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated they had been made aware of R2's low O2 sats some mornings; and stated most mornings they were at the facility where they could recheck the O2 sat. LALD/CNS-C stated they were not sure if the ULPs were moving the oximeter or how long they were keeping the oximeter on the resident when they checked the O2 sat. LALD/CNS-C stated they would expect the staff to call or text the nurse right away if the oxygen saturation were below 89% and they would instruct the ULP to recheck the O2 sat after they had talked to the resident or after getting the resident up. The licensee's Delegation of Assisted Living Tasks policy dated April 16, 2022, indicated the clinician may delegate procedures according to the following: - the clinician instructed the home health aide in the proper methods to perform the procedure with respect to each resident; - the clinician provided the home health aide with written instructions specific to the resident; - the home health aide demonstrated to the clinician competence in the procedure; - the procedure is documented in the resident's clinical record; and - the home health aide's competence is documented in his/her personnel file.	01420			

Minnesota Department of Health

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01420	Continued From page 43 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01420			
01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning	01500			

Minnesota Department of Health

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01500	Continued From page 44 and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure annual training included all required topics for each 12 months of employment, for one of one unlicensed personnel ((ULP)-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	01500			

Minnesota Department of Health

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01500	Continued From page 45 situation has occurred only occasionally). The findings include: ULP-B was hired on November 10, 2021, to provide direct care to the residents. On January 28, 2025, at 8:10 a.m., the surveyor observed ULP-B assist R3 with medication administration. On January 28, 2025, at 8:51 a.m., the surveyor observed ULP-B assist R2 with medication administration. ULP-B's personnel record lacked evidence of the following required topics of annual training in 2022 and 2023: - 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; and - principles of person-centered planning/service delivery. ULP-B's personnel record lacked evidence of the following required topics of annual training in 2024: - 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	01500			

Minnesota Department of Health

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01500	Continued From page 46 disease, or related disorders; - review of provider's policies and procedures; and - principles of person-centered planning/service delivery. On January 29, 2025, at 1:18 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated they usually would go through Educare (common education program online) to check for completed assigned courses but would get a process in place to ensure follow up for verifying the completed courses as assigned. The licensee's Staff Orientation and Education policy dated July 20, 2021, indicated all staff who provided assisted living services would complete eight hours of education for every twelve months of employment and would include the following education topics: - reporting of maltreatment of adults; - review of Assisted Living Bill of Rights and staff responsibilities related to ensuring the exercise and protection of those rights; - review of the organization's policies and procedures related to provision of assisted living services and how to implement them; - infection control techniques used in the home; - effective approaches to use to problem solve when working with a resident's challenging behaviors and how to communicate with residents who have dementia, Alzheimer's Disease, or related disorders; and - the principles of person-centered planning and service delivery and how they apply to direct support services provided by staff. No further information provided.	01500			

Minnesota Department of Health

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01500	Continued From page 47	01500			
01530 SS=F	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure all employees received eight hours of initial dementia care training within the first 160 working hours of employment for	01530			

Minnesota Department of Health

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01530	Continued From page 48 direct care employees as required for one of two unlicensed personnel ((ULP)-A); and failed to ensure all employees received two hours of annual dementia care training for direct care employees as required for one of one 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 the residents). The findings include: ULP-A ULP-A was hired on October 7, 2024, to provide direct care to the residents. On January 31, 2025, at 10:51 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C indicated in an email that ULP-A had worked a total of 240 hours from October 3, 2024, to present. ULP-A's transcript dated January 29, 2025, included the following initial dementia care training: - Dementia - A Refresher (1 hour) completed on October 21, 2024; - Dementia - Activities (0.75 hours) completed on October 21, 2024; - Dementia - Person-Centered Care (0.75 hours) completed on October 21, 2024; - Dementia - Problem Solving - Anger and Aggression (0.5 hours) completed on October 21, 2024; and	01530			

Minnesota Department of Health

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01530	Continued From page 49 - Dementia 2 - Communication (1.25 hours) completed on October 21, 2024. ULP-A had a total of 4.25 hours completed within 160 hours of working for the licensee. ULP-A's personnel record lacked the required eight hours of dementia care training within 160 hours of working for the licensee. ULP-B ULP-B was hired on November 10, 2021, to provide direct care to the residents. ULP-B's personnel record lacked dementia care training in 2022 and 2023. On January 29, 2025, at 3:34 p.m., LALD/CNS-C stated dementia care training was assigned in Educare (popular online training) for the ULPs to complete but the training was not followed up on. The licensee's Dementia Education policy dated April 16, 2022, indicated direct care employees would complete at least eight hours of initial education within 160 working hours of employment start date that included the following topics: an explanation of Alzheimer's disease and other dementias, assistance with activities of daily living, problem solving with challenging behaviors, communication skills, and person-centered planning and service delivery. Also, the policy indicated direct care employees would complete at least two hours of education on topics related to dementia for each twelve months of employment. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530			

Minnesota Department of Health

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01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed	01730			

Minnesota Department of Health

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01730	Continued From page 51 when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop an individualized medication management record with the required content for two of two residents (R2, R3). 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 R2 was admitted to licensee on December 22, 2023, with diagnoses of congestive heart failure (progressive heart disease that affects pumping action of the heart muscles) and diabetes. R2's Service Plan dated December 22, 2023, and reviewed on January 5, 2024, indicated R2 received the following services for assistance with dressing, grooming, toileting, mobility, transfers, meals, medications, home making, and shopping. R2's Medication Management Plan dated December 22, 2023, and reviewed on January 5, 2024, indicated R2 received assistance with medication administration. R2's Medication	01730			

Minnesota Department of Health

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01730	Continued From page 52 Management Plan was not reviewed at least annually. Also, R2's Medication Management Plan identified storage/security/risk for diversion to be completed daily by the registered nurse (RN)/licensed practical nurse (LPN)/ULP but lacked identification of how medications were to be stored according to the resident's needs, preferences, and/or manufacturer. R2's Medication Administration Record (MAR) dated January 2025, indicated the following: - finasteride 5 mg tablet, take one tablet by mouth in the morning. R2's MAR lacked specific instructions for handling the medication for women who are pregnant or may become pregnant to avoid contact with broken or crushed finasteride as this may harm the fetus. R2's record lacked the following required content: - a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; and - documentation of specific resident instructions relating to the administration of medications. R3 R3 was admitted to licensee on November 8, 2024, with diagnosis of pressure ulcers. R3's Service Plan dated November 8, 2024, and reviewed on November 22, 2024, indicated R3 received the following services for assistance with dressing, grooming, toileting, mobility, transfers, meals, medications, home making and shopping. R3's Medication Management Plan dated November 8, 2024, and reviewed on November 22, 2024, indicated R3 received assistance with medication administration. R3's Medication	01730			

Minnesota Department of Health

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01730	Continued From page 53 Management Plan identified, Storage/Security/Risk for diversion to be completed by the staff but lacked identification of how medications were to be stored according to the resident's needs, preferences and/or manufacturer. R3's MAR dated January 2025, indicated the following: - linzess 290 micromilligrams (mcg) capsule, take one capsule by mouth every morning. R3's MAR lacked specific resident instructions to take on an empty stomach, at least thirty minutes before a meal; - Milk of Magnesia suspension (magnesium hydroxide) 400 ml per 5 ml, take 5 ml by mouth if needed at bedtime for constipation. R3's MAR lacked specific instructions to take the suspension with a full glass (eight ounces) of liquid; and to take other medications at least two hours before or after taking milk of magnesia; and - naloxone HCL 4 mg nasal spray, instill one spray by nasal route once if needed for opioid antidote. R3's MAR lacked specific symptoms to give the medication when there is an opioid overdose; and specific instructions on how to give the inhaler along with instructions for calling 911 after the first dose is given and what to do until emergency medical help arrived. R3's record lacked the following required content: - a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; - documentation of specific resident instructions relating to the administration of medications; On January 31, 2025, at 11:15 a.m., licensed	01730			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 38061	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/31/2025
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01730	Continued From page 54 assisted living director/clinical nurse supervisor (LALD/CNS)-C stated the individualized medication management plan could be more individualized with the missing content. The licensee's undated Medication Management Program policy indicated admission to the Medication Management Program is at the discretion of the registered nurse (RN) but failed to indicate a current individualized medication management record was required for each resident receiving medication management. The policy failed to identify the individualized medication management plan must be reviewed annually and as needed with changes. Also, the policy failed to identify the individualized medication management record must contain the following: - a statement describing the medication management services that will be provided; - a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; - documentation of specific resident instructions relating to the administration of medications; - identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; - identification of medication management tasks that may be delegated to unlicensed personnel; - procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and - any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse	01730			

Minnesota Department of Health

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01730	Continued From page 55 reactions. According to MedlinePlus website accessed on February 18, 2025, at 12:13 p.m., finasteride that is broken or crushed should be avoided by women who may became pregnant or are pregnant as this may cause harm to a fetus. According to MedlinePlus website accessed on February 18, 2025, at 8:45 a.m., Linzess should be given on an empty stomach, at least thirty minutes before a meal; and Linzess capsules should be swallowed whole and not split, chewed, crushed. According to MedlinePlus website accessed on February 18, 2025, at 8:57 a.m., magnesium hydroxide (Milk of Magnesia suspension) should be taken with a full glass (eight ounces) of liquid; the oral suspension should be shaken well before each use; and to take other medications at least two hours before or after taking magnesium hydroxide. According to MedlinePlus website accessed on February 18, 2025, at 10:01 a.m., naloxone should be given for symptoms of an opioid overdose that include excessive sleepiness, not awakening when spoken to in a loud voice or when the middle of the chest is rubbed firmly, shallow or stopped breathing, or small pupils (black circles in the center of the eyes). The following steps should be followed to administer the inhaler: 1. Lay the person on their back to give the medication; 2. Remove the naloxone nasal spray from the box. Peel back the tab to open the spray; 3. Do not prime the nasal spray before using it; 4. Hold the naloxone nasal spray with the thumb on the bottom of the plunger and your first and middle fingers on either side of the	01730			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 38061	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/31/2025
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01730	Continued From page 56 nozzle; 5. Gently insert the tip of the nozzle into one nostril, until the fingers on either side of the nozzle are against the bottom of the person's nose. Provide support to the back of the person's neck with hand to allow the head to tilt back; 6. Press the plunger firmly to release the medication; 7. Remove the nasal spray nozzle from the nostril after giving the medication; 8. Turn the person on their side (recovery position) and call for emergency medical assistance immediately after giving the first naloxone dose; 9. If the person does not respond by waking up, to voice or touch, or breathing normally or responds and then relapses, give another dose. If needed, give additional doses (repeating steps 2 through 7) every two to three minutes in alternate nostrils with a new nasal spray each time until emergency medical assistance arrives. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730			
01750 SS=F	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident.	01750			

Minnesota Department of Health

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01750	Continued From page 57 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to have the registered nurse (RN) train the unlicensed personnel (ULP) in the proper methods to perform the task or procedure prior to the delegation of medication administration for two of two unlicensed personnel ((ULP)-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, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On January 28, 2025, at 8:51 a.m., the surveyor observed ULP-B administer Novolog insulin and Semglee insulin to R2. ULP-B failed to perform a safety test or air shot prior to administration of both insulins per their manufacturers' instructions. R2 R2 was admitted to licensee on December 22, 2023, with diagnoses of congested heart failure (progressive heart disease that affects pumping action of the heart muscles) and diabetes. R2's Medication Administration Record (MAR) dated January 2025, indicated R2 received Novolog PenFill 100 unit (u) per milliliter (ml) three times per day with instructions to inject five units under the skin with breakfast, lunch and	01750			

Minnesota Department of Health

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01750	Continued From page 58 dinner; and Semglee 100 u/ml once a day with instructions to inject 40 units under the skin. ULP-A ULP-A was hired on October 7, 2024, to provide direct care to the residents. ULP-A's undated Skill Competency, Medication and Treatment - Insulin Administration indicated ULP-A had passed a competency evaluation for insulin administration completed by the RN. ULP-A's competency evaluation indicated it did not replace manufacturers' instructions for unique equipment and/or circumstance related to needs outlined in an individualized plan of care. The competency did not include a procedure for performing a safety test or air shot prior to insulin administration when using an insulin pen. ULP-B ULP-B was hired on November 10, 2021, to provide direct care to the residents. ULP-B's undated Skill Competency, Medication and Treatment - Insulin Administration indicated ULP-B had passed a competency evaluation for insulin administration completed by the RN. ULP-B's competency evaluation indicated it did not replace manufacturers' instructions for unique equipment and/or circumstance related to needs outlined in an individualized plan of care. The competency did not include a procedure for performing a safety test or air shot prior to insulin administration when using an insulin pen. On January 28, 2025, at 9:43 a.m., the surveyor asked ULP-B if they had been trained on how to prime an insulin pen. ULP-B stated the medication comes from the pharmacy and we put this in the fridge. The nurse usually does that.	01750			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 38061	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/31/2025
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01750	Continued From page 59 On January 28, 2025, at 9:45 a.m., the surveyor asked licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C if the ULPs had been trained to prime R2's insulin pens prior to each administration of the insulin. LALD/CNS-C stated, "prime it? How?" The surveyor informed LALD/CNS-C of the manufacturers' recommendations for priming of the insulin pens prior to each administration. LALD/CNS-C stated, "Oh, not aware of this." The surveyor observed LALD/CNS-C on their computer looking up information on how to prime insulin pens. The manufacturer's instructions for Novolog PenFill (insulin aspart) revised February 2023, indicated small amounts of air may collect in the cartridge during normal use and an air shot must be done before each injection to avoid injecting air and to make sure the prescribed dose is administered. The manufacturer's instructions for Semglee (insulin glargine) revised November 2023, indicated to perform a safety test before each injection to check the pen and needle to make sure they are working properly; and to make sure the proper dose is administered. The safety test is performed by selecting two units by turning the dose selector until the dose pointer is at the 2 mark and then pressing the injection button all the way in to verify insulin coming out of the needle tip. The licensee's Delegation of Assisted Living Tasks policy dated April 16, 2022, indicated the clinician (RN) may delegate procedures according to the following: - RN instructed the HHA in proper methods to perform the procedure with respect to each	01750			

Minnesota Department of Health

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01750	Continued From page 60 resident; - RN provided the HHA with written instructions specific to the resident; - HHA demonstrated to the RN competence in the procedure; - the procedure is documented in the residents clinical record; and - the HHA's competence is documented in his/her personnel file. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750			
01760 SS=F	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were administered as prescribed; failed to document the reason why medication	01760			

Minnesota Department of Health

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01760	Continued From page 61 administration was not completed as prescribed; failed to document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed; and failed to ensure as needed (PRN) medications had documentation of effectiveness after administration for two of two residents (R2, R3). 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: MEDICATION ERROR R2 was admitted to licensee on December 22, 2023, with diagnoses of congestive heart failure (progressive heart disease that affects pumping action of the heart muscles) and diabetes. R2's Service Plan dated December 22, 2023, and reviewed on January 5, 2024, indicated R2 received the following services for assistance with dressing, grooming, toileting, mobility, transfers, meals, medications, home making, and shopping. R2's Consultation Form dated January 6, 2025, included R2's physician ordered: - metformin 1,000 milligrams (mg) take one tablet by mouth twice a day with breakfast and supper; and - Novolog PenFill 100 units (u) per 100 milliliters (ml) inject 5 u under the skin twice a day with breakfast, lunch and dinner (the order was	01760			

Minnesota Department of Health

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01760	Continued From page 62 conflicting with instructions to give twice a day and to give with breakfast, lunch and dinner). On January 28, 2025, at 8:51 a.m., the surveyor observed unlicensed personnel (ULP)-B administer R2's metformin and Novolog PenFill without breakfast as ordered. On January 28, 2025, at 10:17 a.m., the surveyor observed R2 still had not received food after the medication administration of metformin and Novolog PenFill as ordered to be given with breakfast. On January 28, 2025, at 10:35 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated to ULP-B, they had this conversation before and instructed ULP-B they needed to make sure the resident was sitting up and had food in front of them when administering medications that were ordered to be given with food. LALD/CNS-C had instructed ULP-B to recheck R2's blood glucose now since it had been two hours since R2 had received his insulin. MEDICATION ADMINISTRATION DOCUMENTATION R2 R2 was admitted to licensee on December 22, 2023, with diagnoses of congestive heart failure (progressive heart disease that affects pumping action of the heart muscles) and diabetes. R2's Service Plan dated December 22, 2023, and reviewed on January 5, 2024, indicated R2 received the following services for assistance with dressing, grooming, toileting, mobility, transfers, meals, medications, home making, and shopping. R2's Medication Administration Record (MAR)	01760			

Minnesota Department of Health

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01760	Continued From page 63 dated January 2025, indicated the following medications lacked documentation as noted below: - amlodipine besylate 10 mg, take one tablet by mouth every day for blood pressure, lacked documentation at 8:00 a.m. on January 1, 2025, January 2, 2025, January 3, 2025, and January 6, 2025; - atorvastatin 40 mg, take one tablet by mouth daily at bedtime, lacked documentation at 8:00 p.m. on January 4, 2025, and January 5, 2025; - carvedilol 25 mg, take one tablet by mouth twice a day, lacked documentation at 8:00 a.m. on January 1, 2025, January 2, 2025, January 3, 2025, and January 6, 2025; and at 5:00 p.m. on January 1, 2025, January 4, 2025, January 5, 2025, and January 18, 2025; - Enema Ready to Use, instill one enema into the rectum every day for constipation, lacked documentation at 8:00 a.m. every day in the month of January except on January 4, 2025, January 5, 2025, January 7, 2025, and January 8, 2025; January 11, 2025, and January 28, 2025; - ferrous sulfate 325 mg, take one tablet by mouth once daily, lacked documentation at 8:00 a.m. on January 1, 2025, January 2, 2025, January 3, 2025, January 6, 2025, January 9, 2025, and January 10, 2025; - finasteride 5 mg, take one tablet by mouth in the morning, lacked documentation at 8:00 a.m. on January 1, 2025, January 2, 2025, January 3, 2025, and January 6, 2025; - Jardiance 10 mg, take one tablet by mouth once daily, lacked documentation at 8:00 a.m. on January 1, 2025, January 2, 2025, January 3, 2025, and January 6, 2025; - Lurasidone HCL 80 mg, take one tablet by mouth with supper, lacked documentation at 5:00 p.m. on January 1, 2025, January 5, 2025, and January 18, 2025;	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 38061	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/31/2025
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01760	Continued From page 64 - metformin HCL 1,000 mg, take one tablet by mouth twice a day with breakfast and supper, lacked documentation at 8:00 a.m. on January 1, 2025, January 2, 2025, January 3, 2025, and January 6, 2025; and at 5:00 p.m. on January 1, 2025, January 4, 2025, January 5, 2025, and January 18, 2025; - Novolog PenFill 100 u per ml, inject 5 u under the skin twice a day with breakfast, lunch, and dinner, lacked documentation at 8:00 a.m. on January 1, 2025, January 2, 2025, January 3, 2025, and January 6, 2025; at 12:00 p.m. on January 1, 2025, January 2, 2025, January 3, 2025, January 6, 2025, and January 8, 2025; and at 5:00 p.m. on January 1, 2025, January 4, 2025, January 5, 2025, and January 18, 2025; - olanzapine 5 mg, take one tablet by mouth once daily, lacked documentation at 5:00 p.m. on January 1, 2025, January 4, 2025, January 5, 2025, and January 18, 2025; - pantoprazole Sod DR 40 mg, take one tablet by mouth every morning before breakfast, lacked documentation at 7:00 a.m. on January 1, 2025, thru January 10, 2025, January 12, 2025, January 13, 2025, and January 14, 2025; -Semglee 100 u per ml, inject 40 u under the skin once a day, lacked documentation at 8:00 a.m. on January 1, 2025, January 2, 2025, January 3, 2025, and January 6, 2025; - tamsulosin HCL 0.4 mg, take two capsules by mouth at bedtime, lacked documentation at 9:00 p.m. on January 4, 2025, January 5, 2025, and January 18, 2025; - torsemide 20 mg, take two tablets by mouth everyday for excess fluid, lacked documentation at 8:00 a.m. on January 1, 2025, January 2, 2025, January 3, 2025, and January 6, 2025; - nicotine 21 mg per 24 hour patch, apply one patch topically every day to quit smoking, lacked documentation at 8:00 a.m. on January 1, 2025,	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 38061	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/31/2025
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01760	Continued From page 65 January 2, 2025, January 3, 2025, and January 6, 2025; and - triamcinolone 0.1% cream, apply thin layer topically twice daily for dermatitis, lacked documentation at 8:00 a.m. on January 1, 2025, January 2, 2025, January 3, 2025, January 6, 2025, January 9, 2025, and January 10, 2025. R2's MAR dated January 2025, indicated PRN medications were administered and lacked documentation of follow up for effectiveness of the medication as follows: - hydrocodone-acetaminophen 5-325 mg, take one tablet by mouth every six hours as needed for pain was given around 5:00 p.m. on January 24, 2025, January 25, 2025, and January 26, 2025; - hydroxyzine HCL 25 mg, take one tablet by mouth three times daily if needed for anxiety was administered three times in the month of January; and - olanzapine 2.5 mg, take one tablet by mouth two times daily if needed for agitation was administered one time in the month of January. R3 R3 was admitted to licensee on November 8, 2024, with diagnosis of pressure ulcers. R3's Service Plan dated November 8, 2024, and reviewed on November 22, 2024, indicated R3 received the following services for assistance with dressing, grooming, toileting, mobility, transfers, meals, medications, home making, and shopping. On January 28, 2025, at 8:10 a.m., during medication observation, the surveyor observed ULP-B give R3 polyethylene glycol 3350 granules mixed in a glass of red juice. Also, during the medication observation ULP-B stated to the	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 38061	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/31/2025
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01760	Continued From page 66 surveyor, R3 was out of his Enulose medication and could not administer that medication. R3's MAR dated January 2025, indicated the following scheduled medications lacked documentation as noted below: - Linzess 290 micrograms (mcg), take one capsule by mouth every morning, lacked documentation at 8:00 a.m. on January 7, 2025, January 8, 2025, and January 27, 2025; and - Enulose 10 gm per 15 ml solution, take 30 ml by mouth in the morning and 30 ml in the evening, indicated this medication was on hold for January 28th, 2025. The MAR did not indicate this medication was not given due to not having the medication. R3's MAR dated January 2025, indicated PRN medications were administered and lacked documentation of follow up for effectiveness of the medication as followed: - cyclobenzaprine 10 mg tablet, give one and a half tablets (15 mg) by mouth in the morning, at noon, and before bedtime as needed for muscular spasms was administered eighteen times in the month of January; - hydroxyzine pam 25 mg capsule, take one capsule (25mg) by mouth every four hours for anxiety was administered four times in the month of January; - melatonin 3 mg tablet, take one tablet (3 mg) by mouth if needed at bedtime for sleep was administered one time in the month of January; - oxycodone 5 mg tablet, take one tablet (5 mg) by mouth every six hours as needed for pain was administered four times in the month of January; - oxycodone 5mg tablet, take one tablet (5 mg) by mouth every eight hours if needed for pain was administered fifteen times in the month of January;	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 38061	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/31/2025
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01760	Continued From page 67 - polyethylene glycol 3350 granules, take one capful (17 grams) by mouth if needed in the morning and before bedtime for constipation, lacked documentation on January 28, 2025, that this medication was administered as observed by the surveyor during a medication observation. This medication was documented that it was administered six times in the month of January; - Tylenol Ex-Str 500mg tablet, take two tablets (1,000 mg) by mouth every six hours as needed for mild pain or fever was administered two times in the month of January.; and - lidocaine-prilocaine 2.5% cream, apply topically to the affected area if needed each day (prior to wound cleaning and dressing) was administered six times in the month of January. On January 27, 2025, at 10:10 a.m., during the entrance conference, LALD/CNS-C stated the staff were supposed to check in with the resident one hour after a PRN medication was given to verify the effectiveness and to update the nurse. On January 29, 2025, at 9:27 a.m., LALD/CNS-C stated they planned to do more teaching during the next quality improvement meeting with staff as they expected staff to sign off on each medication that was administered. LALD/CNS-C stated the medications were preset-up from the pharmacy and had the date and time on each pack to be administered. LALD/CNS-C stated they had always double checked the medications to make sure the resident got their medications and thought this was an oversight from staff. The licensee's Medication Documentation policy dated April 16, 2022, indicated each medication administered would be documented in the resident's clinical record. The policy indicated if the administration of one or more medications	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 38061	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/31/2025
NAME OF PROVIDER OR SUPPLIER ROBERTS HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 7749 NEWTON AVENUE NORTH BROOKLYN PARK, MN 55444			
(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
01760	Continued From page 68 were not completed, staff would document the reason why the medication administration was not administered and follow up procedures to meet the resident's needs. Also, the policy indicated for PRN medications, documentation would include the reason for the medication and follow up to determine its effectiveness. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760			
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were stored securely for two of two residents (R2, R3) with medication management services. 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:	01880			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 38061	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/31/2025
NAME OF PROVIDER OR SUPPLIER ROBERTS HOUSE			STREET ADDRESS, CITY, STATE, ZIP CODE 7749 NEWTON AVENUE NORTH BROOKLYN PARK, MN 55444		
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01880	Continued From page 69 R2 On January 27, 2025, at 11:12 a.m., during a facility tour, the surveyor observed unsecured medications in room 1 (R2's room) for antifungal powder and triamcinolone cream. On January 28, 2025, at 9:39 a.m., during a medication observation, the surveyor observed unsecured medications in room 1 (R2's room) for antifungal powder and triamcinolone cream. R2 was admitted to licensee on December 22, 2023, with diagnoses of congestive heart failure (progressive heart disease that affects pumping action of the heart muscles) and diabetes. R2's Service Plan dated December 22, 2023, and reviewed on January 5, 2024, indicated R2 received the following services for assistance with dressing, grooming, toileting, mobility, transfers, meals, medications, home making, and shopping. R2's Medication Management Plan dated December 22, 2023, and reviewed on January 5, 2024, indicated R2's Medication Management Plan identified, Storage/Security/Risk for diversion to be completed daily by the RN/LPN/CNA but lacked identification of how medications were to be stored according to the resident's needs, preferences and/or manufacturer. R2's Comprehensive Physical Assessment dated October 31, 2024, indicated R2 required assistance with medications and took medications inappropriately. R3 On January 27, 2025, at 11:12 a.m., during a	01880			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 38061	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/31/2025
NAME OF PROVIDER OR SUPPLIER ROBERTS HOUSE			STREET ADDRESS, CITY, STATE, ZIP CODE 7749 NEWTON AVENUE NORTH BROOKLYN PARK, MN 55444		
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01880	Continued From page 70 facility tour, the surveyor observed unsecured medication in room 2 (R3's room) for silver sulfate. R3 was admitted to licensee on November 8, 2024, with diagnosis of pressure ulcers. R3's Service Plan dated November 8, 2024, and reviewed on November 22, 2024, indicated R3 received the following services for assistance with dressing, grooming, toileting, mobility, transfers, meals, medications, home making, and shopping. R3's Medication Management Plan dated November 8, 2024, and reviewed on November 22, 2024, indicated Storage/Security/Risk for diversion would be completed by the staff but lacked identification of how medications were to be stored according to the resident's needs, preferences and/or manufacturer. R3's Comprehensive Physical Assessment dated January 6, 2025, indicated R3 required assistance with medications and took medications inappropriately. On January 31, 2025, at 11:19 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated R3 had services in addition that came in the home. LALD/CNS-C stated, "I think we could get a treatment cart that locks to protect the medications in the room." LALD/CNS-C stated it was an oversight. The licensee's Storage/Control of Medications policy dated April 16, 2022, indicated when the licensee provided storage of medications outside of the resident's private living space, all prescription drugs would be securely locked in substantially constructed compartments	01880			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 38061	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/31/2025
NAME OF PROVIDER OR SUPPLIER ROBERTS HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 7749 NEWTON AVENUE NORTH BROOKLYN PARK, MN 55444			
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01880	Continued From page 71 according to the manufacturer's directions; and only authorized personnel would have access to the stored medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880			
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 provide care and services according to acceptable health care, medical, or nursing standards for one of one resident (R2) with bed rails. 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: On January 27, 2025, at 11:12 a.m., during a facility tour, the surveyor observed R2's bed had	02310			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 38061	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/31/2025
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02310	Continued From page 72 a hospital style bed with bilateral upper bed rails. The bed rails were grabbed by the surveyor and noted to be secured and not loose. R2 was admitted to licensee on December 22, 2023, with diagnoses of congestive heart failure (progressive heart disease that affects pumping action of the heart muscles) and diabetes. R2's Service Plan dated December 22, 2023, and reviewed on January 5, 2024, indicated R2 received the following services for assistance with dressing, grooming, toileting, mobility, transfers, meals, medications, home making, and shopping. R2's Side-Rail Use Assessment Form dated December 22, 2023, indicated handwritten notes, "bilateral ½ rails (LxWxH) [length by width by height] = 18 inches x 36 inches x 19 inches." The Assessment lacked documentation of specific measurements of each entrapment zone. R2's record did not have any other assessments on side rails. On January 28, 2025, at 2:08 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C confirmed R2's side rail assessment was last completed on December 22, 2023, and did not have any other side rail assessments in R2's record. LALD/CNS-C stated there were no other side rail assessments cause the bed had not changed as R2 had the same bed. The licensee's Side Rail Use policy dated April 16, 2022, indicated before side rails were implemented, the RN would conduct a side rail assessment that included level of mobility, level of consciousness, level of cognition, presence of orthostatic hypotension, and vision. Also, the	02310			

Minnesota Department of Health

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02310	Continued From page 73 need for side rails would be reassessed and documented as needed, but not less than 90 days. The policy failed to include required documentation for the measurements of the entrapment zones. The FDA's Guidance for Industry and FDA Staff: Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment, revised March 10, 2006, on page 21, Table 3 Summary of FDA Hospital Bed Dimensional Limit Recommendations indicated specific measurement limits for each entrapment zone. According to The Minnesota Department of Health's (MDH) Assisted Living: Resources and Frequently Asked Questions (FAQs) website accessed on February 19, 2025, at 12:17 p.m., indicated under Hospital-style bed rails, the licensee must ensure the bed rail measurements were documented; the bed rail had not shifted; and the bed rail was securely attached to the bed frame per manufacturer recommendations. Also, the website indicated per FDA recommendations, bed rails must be assessed on a frequent, regular basis, and at a minimum it would include an assessment of the bed rail upon initial installation, with each 90-day assessment, or with a change of condition. No further information provided. TIME PERIOD FOR CORRECTION: Two (2) days	02310			

Type: Full
Date: 01/27/25
Time: 12:00:00
Report: 1047251020

Food and Beverage Establishment Inspection Report

Page 1

Location:

Robert's House
7749 Newton Avenue North
Brooklyn Park, MN55443
Hennepin County, 27

Establishment Info:

ID #: 0040960
Risk:
Announced Inspection: No

License Categories:

Expires on: 12/31/22

Operator:

Phone #:
ID #:

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

The following orders were issued during this inspection.

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

3-302.11A(1) ** Priority 1 **

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

RAW EGGS STORED ON UPPER SHELF ABOVE READY TO EAT GRAPES. CORRECTED ON SITE-RELOCATED TO LOWER SHELF

Corrected on Site

2-100 Supervision

2-102.11DEFG ** Priority 2 **

MN Rule 4626.0030DEFGHI The person in charge must be able to demonstrate their knowledge to the inspector of the importance of the following food handling procedures to preventing foodborne disease: handwashing; avoiding cross contamination; avoiding hand contact with ready-to-eat foods; time and temperature requirements for safely refrigerating, hot holding, cooling, and reheating TCS food; hazards of eating raw or undercooked meat, poultry, eggs, and fish; food temperatures and cooking times required to safely cook TCS food including meat, poultry, eggs, and fish; foods identified as major food allergens and the symptoms of an allergic reaction; identification of critical control points in a food service operation and steps to be taken to ensure the points are controlled.

PERSON IN CHARGE WAS NOT ABLE TO PROVIDE FINAL COOK TEMPERATURES. DISCUSSED IMPORTANCE OF COOKING FOOD FULLY WHEN SERVING A HIGHLY SUSCEPTIBLE POPULATION. SUGGESTED HANGING A INFO SHEET IN KITCHEN FOR STAFF TO REFERENCE.

Comply By: 01/27/25

Type: Full
Date: 01/27/25
Time: 12:00:00
Report: 1047251020
Robert's House

Food and Beverage Establishment Inspection Report

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.
CERTIFIED FOOD PROTECTION MANAGER IS SHARED ACROSS THREE HOUSES. CFPM IS ALLOWED TO BE SHARED AMONG A MAX OF TWO HOUSES.

Comply By: 02/28/25

3-500A Microbial Control: cooling

3-501.11

MN Rule 4626.0370 Maintain all stored frozen foods in a frozen state at all times.
FOOD STORED IN GARAGE FREEZER WAS NOT COMPLETELY SOLID & FREEZER TEMPERATURE WAS SET TO 41F. TEMPERATURE OF FREEZER WAS READJUSTED TO 0F AT TIME OF INSPECTION.

Comply By: 01/27/25

Surface and Equipment Sanitizers

Hot Water: = at 160 Degrees Fahrenheit
Location: Dishwasher
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 38 Degrees Fahrenheit - Location: Refrigerator- cream cheese
Violation Issued: No

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

The inspection was completed with the operator and reviewed with MDH Nurse Evaluator R. Quinehan.

The establishment has a residential kitchen and serves food that is prepared that day. The kitchen has wood cabinets, laminate floor, painted walls, solid counter top, and a painted ceiling.

A two basin sink is located in the kitchen. One sink basin is designated for hand washing. A residential dish machine is located in the kitchen.

Discussed hand washing, ware washing, staff illness policy, temperature control, final cook temperatures, cleaning, serving highly susceptible populations, and food handling procedures.

Type: Full
Date: 01/27/25
Time: 12:00:00
Report: 1047251020
Robert's House

Food and Beverage Establishment Inspection Report

Page 3

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 1047251020 of 01/27/25.

Certified Food Protection Manager: Thomasia E. Naya

Certification Number: FM110134 Expires: 03/10/25

Inspection report reviewed with person in charge and emailed.

Signed: _____

Natalie Campbell
Operator

Signed: _____

Holly Sievers
Public Health Sanitarian 2
Metro Office
6512015946
Holly.Sievers@state.mn.us