Electronically Delivered

May 15, 2024

Licensee
Dignity & Compassion Homes LLC
4986 Xylon Avenue North
New Hope, MN 55428

RE: Project Number(s) SL39932015

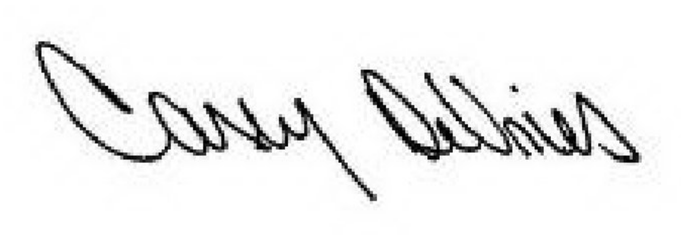
Dear Licensee:

On May 1, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the March 14, 2024, survey were corrected. 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,



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

HHH

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

April 8, 2024

Licensee
Dignity & Compassion Homes LLC
4986 Xylon Avenue North
New Hope, MN 55428

RE: Project Number(s) SL39932015

Dear Licensee:

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

The Minnesota Department of Health completed an initial survey on March 14, 2024, for the purpose assessing compliance with state licensing statutes. At the time of the survey, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G.

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

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

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

The correction order documentation should include the following:

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

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

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

To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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.

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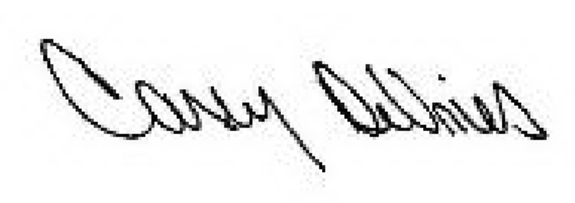
If you have any questions, please contact me.

Sincerely,



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

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39932	A. BUILDING: _____ B. WING _____	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIGNITY & COMPASSION HOMES LLC	4986 XYLON AVENUE NORTH NEW HOPE, MN 55428

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL39932015-0 On March 11, 2024, through March 14, 2024, the Minnesota Department of Health conducted a full routine survey at the above provider, and the following correction orders are issued. At the time of the survey, there were three residents, all of whom received services under the Assisted Living license. An immediate correction order was identified on March 12, 2024, issued for SL39932015-0, tag identification 2310. On, March 14, 2024, at 10:14 a.m., at the time of exit, immediacy of correction order 2310 had not been removed.	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 subd. 1, 2, and 3.	
0 110 SS=C	144G.10 Subdivision 1a Assisted living director license required Each assisted living facility must employ an	0 110		

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0 110	Continued From page 1 assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the licensed assisted living director (LALD) was listed as the director of record for the licensee. This had the potential to affect all the licensee's residents, staff, and visitors. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). These findings include: The licensee's Employee List indicated LALD/registered nurse (LALD/RN)-D was hired on June 12, 2023. On March 11, 2024, at 9:50 a.m., during the entrance conference, the surveyor inquired if the licensee employed a LALD as the surveyor was unable to identify one via the Board of Executives for Long-Term Services and Supports (BELTSS) website during preparation for the survey. Owner/unlicensed personnel (O/ULP)-B and O/ULP-C both stated LALD/RN-D was their current LALD. The surveyor searched the BELTSS website and informed them LALD/RN-D was not listed as the director of record for the	0 110		

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0 110	Continued From page 2 licensee. O/ULP-C stated they were unaware they were required to have a director of record on the BELTSS website. On March 11, 2024, at 10:35 a.m., during the facility tour, the surveyor observed LALD-D's license, expiration date of October 31, 2024, posted on the licensee's postings bulletin board between the living room and kitchen. On March 12, 2024, at 9:39 a.m., LALD/RN-D stated they were the current LALD for the licensee. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 110		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This had the potential to affect all residents of the assisted living facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	0 480		

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0 480	Continued From page 3 resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated March 11, 2024, for the specific Minnesota Food Code deficiencies. The Inspection Report was provided to the licensee on March 12, 2024. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post the 911 emergency phone number	0 640		

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0 640	Continued From page 4 near facility house phones. This had the potential to affect all residents, staff, and visitors at the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The facility was a rambler style home with a main floor and a basement level. On March 11, 2024, at 10:35 a.m., during the facility tour, the surveyor observed three black wireless land-line house phones. Two of the phones were on end-tables in the main level living room and the third was on the main level kitchen counter next to the sink. The surveyor observed the licensee lacked the required posting for 911 near the facility house phones. On March 11, 2024, at 11:15 a.m., owner/unlicensed personnel (O/ULP)-B stated they had three wireless land-line house phones which were all identical. They stated the house phones were for resident and staff use. O/ULP-B stated they were unaware 911 was required to be posted near facility house phones. On March 12, 2024, at approximately 11:00 a.m., the surveyor observed R3 using the kitchen phone. No further information was provided.	0 640		

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0 640	Continued From page 5 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 640		
0 650 SS=F	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) completed training and competency for unlicensed personnel (ULP) providing medications to residents for unplanned times away from home when the licensed nurse	0 650		

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0 650	Continued From page 6 was not available for one of one employee (owner/ULP (O/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: O/ULP-B was hired on June 12, 2023, to provide ownership duties and direct cares to residents. On March 12, 2024, at 7:40 a.m., the surveyor observed O/ULP-B administer medications to R1 O/ULP-B's employee record lacked training for administering medications to residents for unplanned time away. On March 11, 2024, at 1:31 p.m., O/ULP-B and O/ULP-C both stated they were trained to administer medication for unplanned times away by licensed assisted living director/registered nurse (LALD/RN)-D but did not have documentation to support it had been completed. They stated all ULPs were trained to administer medication for unplanned times away but was not documented. The licensee's 7.10 Medication Management - Planned & Unplanned Time Away dated April 12, 2023, indicated, "For unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or properly trained	0 650		

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0 650	Continued From page 7 and competency tested unlicensed personnel may give the resident or resident's representative medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven (7) calendar days with the following requirements." 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 ensure a facility tuberculosis (TB) risk assessment was completed annually. Further, the licensee failed to ensure a TB test screening was completed at the time of hire for	0 660		

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0 660	Continued From page 8 one of two employees (registered nurse (RN)-A). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee's TB Risk Assessment was completed during survey on March 11, 2024, and indicated the facility was at a low risk for TB transmission. RN-A was hired on October 23, 2023, to provide direct cares to residents and oversite to unlicensed personnel (ULP). RN-A's employee record lacked documentation of TB testing results, completed by either TB QuantiFERON (blood test) or two-step Mantoux (skin test), within 90 days prior to their date of hire. On March 11, 2024, at 9:50 a.m., during the entrance conference, owner/unlicensed personnel (O/ULP)-B and O/ULP-C stated they did not have a completed TB Risk Assessment. Both stated they did not know what a TB Risk Assessment was and asked what they needed to do to complete one. RN-A stated they were onsite two to three times per week to work with staff and residents. On March 11, 2024, at 1:31 p.m., O/ULP-B stated they did not complete a TB test screening for	0 660		

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0 660	Continued From page 9 RN-A when they were hired. O/ULP-B stated they would ask RN-A if they had documented TB test results completed within 90 days prior to their date of hire. On March 12, 2024, at 7:30 a.m., O/ULP-B provided the licensee's TB Risk Assessment to the surveyor. O/ULP-B stated it was completed the day before, March 11, 2024, with the help of licensed assisted living director/registered nurse (LALD/RN)-D. The CDC Tuberculosis Screening, Testing, and Treatment of U.S. Health Care Personnel dated May 17, 2019, indicated all health personnel should have a baseline screening and an individual risk assessment, which is necessary for interpreting any test result. All U.S. health care personnel should be screened and tested for TB upon hire. The Minnesota Department of Health TB FAQ indicated each provider licensed by MDH is required to complete a TB risk assessment annually. It further indicated baseline TB screening is required at the time of hire for all health care personnel in Minnesota to include: -assessing for current symptoms of active TB disease; -assessing TB history; and -testing for the presence of Mycobacterium tuberculosis by administering either a two-step tuberculin skin test (TST) or single TB blood test. A previous TB test is acceptable and should be dated within 90 days prior to hire. The licensee's 8.16 Tuberculosis Screening policy dated April 12, 2023, indicated, "The facility will maintain a current community TB risk assessment. The assessment will be updated	0 660		

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0 660	Continued From page 10 annually, using the data and form provided by the Minnesota Department of Health." It further indicated, "Staff whose essential job functions require work within the same air space of home care clients will be screened and tested for tuberculosis prior to the staff being exposed to clients. Baseline (upon hire) screening will be completed, but serial (annual) screening will only be required with increased occupational risk or exposure." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not	0 680		

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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
0 680	Continued From page 11 received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop written emergency preparedness plan (EPP) with all the required content. Further, the license failed to prominently display the licensee's EPP for 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 March 12, 2024, at 12:15 p.m., the surveyor observed owner/unlicensed personnel (O/ULP)-C remove the licensee's EPP from the locked medication closet and provide it to the surveyor. O/ULP-C stated the EPP was always stored in the locked medication closet, and they were not aware it was required to be prominently displayed. The licensee's Emergency Preparedness Plan, undated, lacked the following information: - establish and maintain a comprehensive EP; - how they would coordinate with other health	0 680		

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	39932	A. BUILDING: _____ B. WING _____	03/14/2024

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0 680	Continued From page 12 care facilities and community during an emergency or disaster (natural, man-made, facility, etc.); - documented date of reviews and updates; - risk assessment with documentation; - consider duration of interruptions; - arrangements/contracts to re-establish utility services; - take an all-hazards approach; - categorize the various probable risks/hazards by likelihood of occurrence; - develop strategies for addressing community-based risks (evacuation plans, staffing/shortage, back-up plans); - missing resident plan reviewed quarterly; - an assessment of at-risk population's needs including maintaining independence, communication, transportation, supervision, and medical care; - must identify which staff would assume specific roles in another's absence through succession planning and delegation of authority; - a qualified person who is authorized, in writing, to act in the absence of the administrator; - a process for cooperation and collaboration with local, tribal, regional, State and Federal EP to maintain integrated response; - develop and implement EP policies/procedures; - develop/implement EP policies and procedures to address evacuation and shelter in place for staff and residents which must include: - alternate sources of energy to maintain temperature, safety and sanitary storage of provisions; - alternate sources of energy to fire detection, extinguishing, alarms systems; - sewage and waste disposal; - a tracking system used to document locations of residents, staff, and relocation of staff; - develop policies and procedures to address safe	0 680		

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0 680	Continued From page 13 evacuation from the facility including: - needs of evacuees; - staff responsibilities; - transportation; - alternate communication means; - develop policy and procedures for shelter in place for residents, staff and volunteers who remain at the facility; - develop policy and procedures to address: - systems of medical documentation that preserve resident information; - protects confidentiality; - secures/maintains availability of records; - develop policy and procedures must address use of volunteers including process and role for integration; - develop policy and procedures which address development and arrangements with other facilities or providers to receive residents in the event continuity of services cannot be provided; - develop policies and procedures which address role of the [licensee] under a waiver declared by the secretary in accordance with section 1135; - develop a written communication plan and review/update annually; - communication plan must include all the following names/contact information: - staff; - entities providing services under agreement; - residents' physicians; - other facilities; - volunteers; - communication plan must include contact information for: - Federal, State, tribal, regional, and local EP staff; - State Licensing and Certification Agency; - MN Office of Ombudsman for LTC; - other sources of assistance; - communication plan must include;	0 680		

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0 680	Continued From page 14 - method for sharing information and medical documentation for residence; - means, in event of evacuation, to release resident information; - means of providing information about general condition and location of residents under [licensee's] care; - communication plan must include: - means to provide information about facility occupancy; - needs; - and ability to provide assistance; - authority having jurisdiction; - incident Command Center; - or designee; - communication plan must include A method for sharing information from emergency plan; - must develop and maintain EP training and testing program, review/update annually; - training program must include initial EP training to policies and procedures to all new and existing staff and volunteers; - provide EP training at least annually; - maintain documentation of EP training; - demonstrate staff knowledge of EP; - must implement emergency and standby power systems based on their EP; and - if part of a healthcare system consisting of separately certified healthcare facilities and elects to have a unified and integrated EP, they may choose to participate. On March 14, 2024, at 10:08 a.m., the surveyor notified O/ULP-C their EPP for the licensee lacked nearly all required information. O/ULP-C stated they had read through the EPP requirements once and used some of the highlighted portions of an Appendix Z (EPP requirements) guide when they created their EPP. O/ULP-C stated they would review it again.	0 680		

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0 680	Continued From page 15 No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 730 SS=F	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the	0 730		

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0 730	Continued From page 16 needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the resident record included documentation of all services provided 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 of the residents). The findings include: R1 was admitted to the licensee on September 28, 2023. R1's Assisted Living Service Plan dated September 28, 2023, indicated R1 received services for housekeeping, laundry, meals,	0 730		

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0 730	Continued From page 17 dressing, grooming, bathing, medication management, positioning, and continence care. On March 12, 2024, at 7:40 a.m., the surveyor observed owner/unlicensed personnel (O/ULP)-B administer medications to R1. R1's record lacked documentation of all services provided. On March 12, 2024, at 8:21 a.m., O/ULP-C stated they were not documenting services provided for R1 or any other residents. O/ULP-C stated they were unaware service documentation was required. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730		
0 830 SS=F	144G.45 Subd. 3 Local laws apply Assisted living facilities shall comply with all applicable state and local governing laws, regulations, standards, ordinances, and codes for fire safety, building, and zoning requirements. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to submit a plan review application for a facility remodeling project. 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	0 830		

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0 830	Continued From page 18 resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On March 11, 2024, at 10:45 a.m., survey staff toured the home with owner/unlicensed personnel (O/ULP)-C. During the tour, survey staff observed that the entire basement was under construction. No residents were currently occupying the basement due to the construction. Any alteration to a licensed assisted living facility must go through the plan review and approval process with the Minnesota Department of Health (MDH) before construction work can commence. Any areas of completed construction work may not be permitted to be occupied by assisted living residents until the areas have been cleared for occupancy by the Engineering Services Department at MDH. During an interview with survey staff on March 11, 2024, at 10:45 a.m., O/ULP verified the facility was currently completing a remodeling project. TIME PERIOD FOR CORRECTION: Seven (7) days	0 830		
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	0 970		

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0 970	Continued From page 19 include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the licensee's liability for health, safety, or personal property for one of one resident (R1). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: The licensee provided a blank copy of their Assisted Living Contract which was undated. The licensee's blank Assisted Living Contract along with R1's Assisted Living Contract included the following waiver of liability: "25.MISCELLANEOUS PROVISIONS A. Indemnification. Resident will indemnify and hold harmless Landlord, its employees, and agents from and against any and all claims, actions, damages, and liability and expense in connection with loss of life, personal injury or damage to property, arising from or out of the use by Resident of the rented premises or any other part of Landlord's property, or caused wholly or In part by an act or omission of Resident or Resident's guests or agents."	0 970		

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0 970	Continued From page 20 "B. Insurance. Landlord will maintain appropriate levels and types of Insurance covering the building and Its contents. Because Landlord does not maintain insurance covering the contents of residents' room, Resident is strongly encouraged to carry appropriate levels of liability insurance covering both the contents of the Room, as well as any injury to Resident or Resident's guests occurring within the Room (renter's insurance"). Resident acknowledges and understands that the lack of such Insurance coverage may result in personal loss to and/ or liability of Resident Resident agrees to provide Landlord with a certificate of insurance upon request. In the event Resident's property is damaged or destroyed by fire, efforts to extinguish a fire, or other causes that may be covered by standard fire and extended coverage insurance, or by other insurance coverage, you hereby waive: (a) all claims against Landlord and Its representatives for any such loss or damage; and (b) all rights of subrogation of any insurance company carrying any insurance covering such damage or destruction." R1's record included an Assisted Living Contract signed on September 22, 2023, and included the above language. On March 12, 2024, at 8:21 a.m., owner/unlicensed personnel (O/ULP)-C stated the blank contract provided was currently in use for current and future residents. O/ULP-C stated they were unaware they could not have a waiver of liability in their contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	0 970		

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0 970	Continued From page 21 (21) days	0 970		
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 two of two residents (R1, R2) who utilized hospital 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 of the residents). The findings include: R1 R1 was admitted to the licensee on September 28, 2023, with diagnoses of type two diabetes, polyneuropathy (numbness, burning, pain, or loss of sensation of multiple nerves), schizophrenia, morbid obesity, dependence on others for enabling machines and devices, and adult failure to thrive.	02310		

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02310	Continued From page 22 R1's Assisted Living Service Plan dated September 28, 2023, indicated R1 received services for housekeeping, laundry, meals, dressing, grooming, behavior management, positioning, medication administration, and continence care. R1's resident record included a Handi Medical Supply Safety Checklist and Instructions form signed on November 30, 2023, by owner/unlicensed personnel (O/ULP)-B. The form indicated general safety and care instructions for delivered medical equipment and referred the customer/caregiver to, "follow all manufacturer's directions and adhere to all suggested scheduled maintenance located in the owner's manual provided." R1's resident record included a Bed Rail Assessment form completed by licensed assisted living director/registered nurse (LALD/RN)-D on November 30, 2023, but lacked further assessment of R1's bed rails which was required every 90-days or with change of condition. The form included measurements for the sides of the bed from the foot of the bed of 36 inches and back of the bed of 38 inches. R1's record lacked the following required components: - Measurements of entrapment zones; - Risk vs. benefits discussion (individualized to each resident's risks); - Resident preferences; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements.	02310		

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02310	Continued From page 23 R2 R2 was admitted to the licensee on June 12, 2023, with diagnoses of type two diabetes, chronic obstructive pulmonary disease (COPD), repeated falls, and presence of intraocular lens (an implanted lens used to treat cataracts of other vision problems). R2's Assisted Living Service Plan dated June 12, 2023, indicated R2 received services for housekeeping, laundry, medication management, behavior management, grooming, activities of daily living (ADLs), and bathing assistance. R2's resident record included a Handi Medical Supply Safety Checklist and Instructions form signed on August 14, 2023, by O/ULP-B. The form identified general safety and care instructions for delivered medical equipment. It indicated general safety and care instructions for delivered medical equipment and referred the customer/caregiver to, "follow all manufacturer's directions and adhere to all suggested scheduled maintenance located in the owner's manual provided." R2's resident record included a Bed Rail Assessment form completed by RN-E on August 14, 2023, but lacked further assessment of R2's bed rails which was required every 90-days or with change of condition. The form included measurements for the sides of the beds of 36 inches for one side, and 38 inches for the other side. R2's record lacked the following required components: - Measurements of entrapment zones; - Risk vs. benefits discussion (individualized to	02310		

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02310	Continued From page 24 each resident's risks); - Resident preferences; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements. On March 11, 2024, at 10:45 a.m., during the facility tour, the surveyor observed R1 and R2's rooms which both had hospital beds with half bed rails on both sides of the bed. The bed rails were at the head of the bed. R1's bed was in the middle of the room with the head of the bed pushed up against a wall. R2's bed had the head of the bed and left side of the bed pushed up against the wall in the corner of the room. On March 12, 2024, at 9:14 a.m., O/ULP-C stated the only bed rail assessment completed for R1 was completed on November 30, 2023, which they provided. On March 12, 2024, at 9:22 a.m., R1 stated they had received their hospital bed with bed rails a few months ago and tried to use them when he can to help with mobility while in bed. On March 12, 2024, at 9:32 a.m., O/ULP-C stated both R1 and R2 did not have hospital beds when they were admitted to the licensee. They stated R1's bed rail assessment was completed when they got the bed on November 30, 2023, and R2's bed rail assessment was completed when they got the bed on August 14, 2023. On March 12, 2024, at 9:39 a.m., LALD/RN-D stated they were the nurse who completed R1's bed rail assessment on November 30, 2023.	02310		

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02310	Continued From page 25 LALD/RN-D stated they did complete measurements of the entrapment zones and should have been documented on the assessment form and was aware of the requirement. The surveyor clarified what the measurements on the bed rail assessments meant with LALD/RN-D who stated they were the measurements from the head and foot of the bed to the bed rails and not of the entrapment zones. The surveyor inquired how frequently bed rail assessments were required to be completed, LALD/RN-D stated they should be conducted annually. They stated manufacturer instructions were not referenced. LALD/RN-D stated they did not complete a risk vs. benefits document with the resident but was aware it was a requirement. On March 12, 2024, at 10:05 a.m., O/ULP-C stated they searched and were unable to find any additional documentation to provide for R1 and R2's bed rails. The Food and Drug Administration's (FDA), A Guide to Bed Safety, dated 2000, and revised April 2010, indicated following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) dated	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39932	A. BUILDING: _____ B. WING _____	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIGNITY & COMPASSION HOMES LLC	4986 XYLON AVENUE NORTH NEW HOPE, MN 55428

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02310	Continued From page 26 February 20, 2024, indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, "Documentation about a resident's bed rails includes, but is not limited to: - Purpose and intention of the bed rail; - The resident's bed rail use/need assessment; - Risk vs. benefits discussion (individualized to each resident's risks); - The resident's preferences; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements". Additionally, the MDH website indicated for hospital-style bed rails, the licensee must include in their documentation, the bed rail measurements and that the bed rail has not shifted and is securely attached to the bed frame per manufacturer recommendations. The licensee's Use of Side Rails policy, undated, referenced MN Statute 144D.07. It indicated: ""POLICY: Side rails will not be used in the assisted living setting except in situations where assessment determines they are necessary for safety of the resident. If the resident or resident's	02310		

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	39932	A. BUILDING: _____ B. WING _____	03/14/2024

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02310	Continued From page 27 representative wants side rails on the bed, facility RN will educate the resident/representative about the risks related to side rails and will assess whether the side rails meet FDA standards. If the side rails do not meet safety guidelines, staff will recommend alternative options to reduce the fall risk. Prescriber orders will be obtained for the side rails if indicated. PURPOSE: -To establish parameters for the safe use of side rails -To clarify facility policy on the need for and the safe use of side rails -To identify documentation requirements if side rails are used SPECIAL INSTRUCTIONS: 1. When notified that a resident has a side rail or that the resident or their representative is requesting side rails, the RN will assess and evaluate what the resident's needs are and if the resident can safely utilize the side rail/equipment. Assessment will determine whether the equipment meets the FDA standards for side rails. 2. If the RN determines that the resident is not able to safely use a side rail or that the side rail does not meet the FDA or most current safety guidelines, the RN will recommend that the side rail should be removed and will document this recommendation. The RN will document the teaching provided regarding the risks of using side rails. Documentation will include family members or resident's representative who received the education on the safe use of side rails. 3. If the RN determines that the side rails are not a safe device for the resident, the RN will provide options and alternatives for reducing falls. The RN will document these recommended options and the response from the resident,	02310		

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	39932	A. BUILDING: _____ B. WING _____	03/14/2024

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02310	Continued From page 28 resident's family and/or resident's representative to the RN's recommendations. 4. A detailed document on side rails is found at http://www.fda.gov/downloads/MedicalDevices/DeviceRegulationandGuidance/GuidanceDocuments/ucm072729 .pdf. 5. Detailed information from FDA about Side Rail Safety, including information for both health care providers and for consumers and caregivers is found at http://www.fda.gov/MedicalDevices/ProductsandMedicalProcedures/HomeHealthandConsumer/ConsumerProducts/BedRailSafety/default.htm. The web page for consumers and caregivers can be printed as a handout for facility residents and their families." No further information provided. TIME PERIOD FOR CORRECTION: Immediate	02310		
02410 SS=F	144G.91 Subd. 13 Personal and treatment privacy (a) Residents have the right to consideration of their privacy, individuality, and cultural identity as related to their social, religious, and psychological well-being. Staff must respect the privacy of a resident's space by knocking on the door and seeking consent before entering, except in an emergency or unless otherwise documented in the resident's service plan. (b) Residents have the right to have and use a lockable door to the resident's unit. The facility shall provide locks on the resident's unit. Only a staff member with a specific need to enter the unit shall have keys. This right may be restricted in certain circumstances if necessary for a resident's health and safety and documented in	02410		

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02410	Continued From page 29 the resident's service plan. (c) Residents have the right to respect and privacy regarding the resident's service plan. Case discussion, consultation, examination, and treatment are confidential and must be conducted discreetly. Privacy must be respected during toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to support reasonable privacy during activities for toileting and bathing for 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 of the residents). The findings include: The facility was a two-level rambler style home with a main floor and a basement. There was a bathroom on the main level just outside of three bedrooms and a second bathroom in the basement which was under construction. On March 11, 2024, at 10:35 a.m., during the facility tour, the surveyor observed the main floor bathroom door which was a pocket style door (a sliding door that slides along an upper track and disappears into a wall when opened). The surveyor observed the bathroom door had a	02410		

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02410	Continued From page 30 broken black handle to grip to slide the door open and lacked a locking mechanism. The surveyor inquired if the door locked, owner/unlicensed personnel (O/ULP)-C stated, "no it doesn't, is there any reason why it needs to be able to lock?" The licensee's Resident Privacy Rights policy, undated, indicated, "A copy of the resident privacy rights and the Assisted Living Bill of Rights will be presented to all residents at the time of admission." The licensee's Dignity and Compassion Homes Assisted Living Bill of Rights, undated, taken directly from the Minnesota Department of Health (MDH) Assisted Living Bill of Rights, indicated, "Privacy must be respected during toileting, bathing and other activities of personal hygiene except as needed for resident safety or assistance." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02410		

Minnesota Department of Health
Food, Pools, & Lodging Services
P.O. Box 64975
Saint Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *03/11/24*
Time: 13:00:00
Report: 1043241051

Food and Beverage Establishment Inspection Report

Location:

Dignity and Compassion Homes
4986 Xylon Avenue North
New Hope, MN55428
Hennepin County, 27

Establishment Info:

ID #: 0042470
Risk:
Announced Inspection: No

License Categories:

Expires on: 12/31/24

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 SHELL EGGS IN CARDBOARD BOX STORED ABOVE READY-TO-EAT FOODS (BOXED DINNER, ORANGES, TOMATOES). ADVISED STAFF TO STORE EGGS AT BOTTOM OF COOLER OR IN A PLASTIC STORAGE CONTAINER TO PREVENT CROSS CONTAMINATION. COMPLY WITH ABOVE RULE.

Comply By: 03/11/24

3-300C Protection from Contamination: equipment/utensils, consumers

3-304.14B

MN Rule 4626.0285B Wiping cloths used for wiping counters and other equipment surfaces must be held in an approved sanitizing solution and laundered daily.

WET CLOTH STORED ON KITCHEN SINK. ADVISED STAFF TO STORE CLOTH IN A SANITIZING SOLUTION WITH CHLORINE IN BETWEEN USES. CHLORINE SOLUTION SHOULD MEASURE 50-100 PPM. COMPLY WITH ABOVE RULE.

Comply By: 03/11/24

Surface and Equipment Sanitizers

Hot Water: = at 158 Degrees Fahrenheit
Location: RESIDENTIAL DISH MACHINE
Violation Issued: No

Food and Equipment Temperatures

Type: Full
Date: *03/11/24*
Time: 13:00:00
Report: 1043241051
Dignity and Compassion Homes

Food and Beverage Establishment Inspection Report

Process/Item: MILK
Temperature: 41 Degrees Fahrenheit - Location: COOLER
Violation Issued: No

Process/Item: BUTTER
Temperature: 41 Degrees Fahrenheit - Location: COOLER
Violation Issued: No

Process/Item: CREAM CHEESE
Temperature: 41 Degrees Fahrenheit - Location: COOLER
Violation Issued: No

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

Discussed date marking, illness policy, sanitizer use, ware washing, temperature control, cleaning, pest control, vomit/fecal procedures, test kits, food storage, and food handling procedures.

Inspection was completed with R. White. Joey Keen was the lead Health Regulation Division Nurse Evaluator on site completing the site survey.

***Foods cooked by the facility staff for clients should be fully cooked and prepared for same day service only, with leftovers discarded.

***This facility has a residential kitchen with residential equipment/dish machine and wooden cabinetry. The kitchen finishes and surfaces are well maintained. Contact Health Regulation Division for plan review when facility undergoes remodeling.

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 1043241051 of 03/11/24.

Certified Food Protection Manager: Augusta White

Certification Number: FM116596 Expires: 04/27/26

Inspection report reviewed with person in charge and emailed.

Signed: _____
Randy White
PIC

Signed: Blia Lor
Blia Lor
Public Health Sanitarian I
651-355-0641
blia.lor@state.mn.us