



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

November 26, 2024

Licensee
Miles Vents Incorporated
5817 Decatur Avenue North
New Hope, MN 55428

RE: Project Number(s) SL37091015

Dear Licensee:

On October 23, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the August 7, 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,

A handwritten signature in black ink, appearing to read 'Jodi Johnson'.

Jodi Johnson, Supervisor
State Evaluation Team
Email: jodi.johnson@state.mn.us
Telephone: 507-344-2730 Fax: 1-866-890-9290

JMD



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

September 19, 2024

Licensee

Miles Vents Incorporated
5817 Decatur Avenue North
New Hope, MN 55428

RE: Project Number(s) SL37091015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 7, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement.

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

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

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

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

0830 - 144g.45 Subd. 3 - Local Laws Apply - \$3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$3,000.00**. 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 black ink, appearing to read "Jodi Johnson", with a stylized flourish extending to the right.

Jodi Johnson, Supervisor

State Evaluation Team

Email: jodi.johnson@state.mn.us

Telephone: 507-344-2730 Fax: 1-866-890-9290

JMD

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37091	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/07/2024
NAME OF PROVIDER OR SUPPLIER MILES VENTS INCORPORATED		STREET ADDRESS, CITY, STATE, ZIP CODE 5817 DECATUR 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: SL37091015 On August 5, 2024, through August 7, 2024, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were five residents; five receiving services under the provider's Assisted Living Facility license. 0830: An immediate correction order was issued on August 5, 2024, at a level 3/Widespread (I). The immediacy was lifted on August 7, 2024, but remains at a level 3/Widespread.	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.		
0 250 SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a	0 250			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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0 250	Continued From page 1 provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4, or interferes with or impedes access by the Office of Ombudsman for Mental Health and Developmental Disabilities according to section 245.94, subdivision 1; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter;	0 250			

Minnesota Department of Health

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0 250	Continued From page 2 (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to show they met the requirements of licensure, by attesting the managerial officials who oversaw the day-to-day operations understood applicable statutes and rules; nor developed and/or implemented current policies and procedures as required with records reviewed. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on August 5,	0 250			

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0 250	Continued From page 3 2021, at approximately 12:00 p.m. licensed assisted living director/registered nurse (LALD/RN)-A 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 have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section] 144G.45, my building(s) must comply with subdivisions 1-3 of the section, as applicable section Laws 2020, 7th Spec. [special] Sess [session]., chpt. [chapter] 1. art. [article] 6, sect. 17. - I have read and fully understand Minn. Stat. sect. 144G.80, 144G.81. and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22, my building(s) must comply with these sections if applicable. - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G. - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659. - Reporting of Maltreatment of Vulnerable Adults. - Electronic Monitoring in Certain Facilities. - I understand pursuant to Minn. Stat. sect. 13.04	0 250			

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0 250	Continued From page 4 Rights of Subjects of Data, the Commissioner will use information provided in this application, which may include an in-person or telephone conference, to determine if the applicant meets requirements for assisted living licensing. I understand I am not legally required to supply the requested information; however, failure to provide information or the submission of false or misleading information may delay the processing of my application or may be grounds for denying a license. I understand that information submitted to the commissioner in this application may, in some circumstances, be disclosed to the appropriate state, federal or local agency and law enforcement office to enhance investigative or enforcement efforts or further a public health protective process. Types of offices include Adult Protective Services, offices of the ombudsmen, health-licensing boards, Department of Human Services, county or city attorneys' offices, police, local or county public health offices. - I understand in accordance with Minn. Stat. sect. 144.051 Data Relating to Licensed and Registered Persons (opens in a new window), all data submitted on this application shall be classified as public information upon issuance of a provisional license or license. All data submitted are considered private until MDH issues a license. - I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659 governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract.	0 250			

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0 250	Continued From page 5 - I have examined this application and all attachments and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct, and complete. I will notify MDH, in writing, of any changes to this information as required. - 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 the authorized agent on January 12, 2024. The licensee had an assisted living license issued on March 1, 2024, with an expiration date of February 28, 2025. The licensee failed to ensure the following policies and procedures were developed and/or implemented: (1) requirements in section 626.557, reporting of maltreatment of vulnerable adults; (3) orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; (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	0 250			

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0 250	Continued From page 6 health care providers as appropriate; (12) medication and treatment management; and (13) delegation of tasks by registered nurses or licensed health professionals. As a result of this survey, the following orders were issued: 0640, 1370, 1380, 1470, 1500, 1530, 1610, 1620, 1700, 1710, 1730, 1760, 1880, 1910, 1940, 1950, 1960, and 2320, indicating the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.08 to 144G.95. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 250			
0 460 SS=F	144G.41 Subdivision 1 Minimum requirements (5) provide a means for residents to request assistance for health and safety needs 24 hours per day, seven days per week; (6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract; (7) permit residents access to food at any time; (8) allow residents to choose the resident's visitors and times of visits; (9) allow the resident the right to choose a roommate if sharing a unit; (10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living	0 460			

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0 460	Continued From page 7 facility must not lock a resident in the resident's unit; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide a working means for residents to request assistance for health and safety needs 24 hours a day, seven days a week. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a 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 the residents). The findings include: On August 5, 2024, at 12:15 p.m. education coordinator (EC)-D stated the residents did not have a means to summon staff. The facility staff were typically in the kitchen and the residents would come to them if they needed something. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 460			
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at	0 470			

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0 470	Continued From page 8 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 interview and record review, the licensee failed to ensure a staffing plan was developed, potentially affecting all licensee's current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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	0 470			

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0 470	Continued From page 9 failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On August 5, 2024, at 12:15 p.m. licensed assisted living director/registered nurse (LALD/RN)-A stated the facility did not have a staffing plan, evaluated twice a year. The licensee's staffing policy dated August 1, 2021, indicated: "The Clinical Nurse Supervisor will prepare and implement a 24-hour daily staffing plan that ensures adequate staffing to meet residents' needs at all times, including reasonably foreseeable needs." "1. The staffing plan to determine the required staffing level is prepared by the clinical nurse supervisor. 2. The plan considers the number of qualified direct-care staff (home health aides} to meet the residents' needs throughout the day and night. 3. The staffing plan is based on an evaluation of the appropriateness of the staffing levels in the facility and is reviewed at least twice a year. Considerations include: · The staffing requirements to meet the scheduled and reasonably foreseeable unscheduled needs of the residents based on the assessment and service plan · The acuity level of the residents based on the nursing assessment · The facility's ability to respond promptly and effectively to residents · Staff experience, training and competence · Dementia care requirements · The physical layout of the residence 4. Residents are provided with a means to request assistance for health and safety needs 24	0 470			

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0 470	Continued From page 10 hours/day 7 days/week; during night shifts, the home health aide will respond to resident requests for assistance as soon as possible. 5. A daily staffing schedule is prepared by the clinical nurse supervisor and addresses: · Home health aide work schedules for each home health aide showing all work shifts with days/hours worked · The home health aide's resident assignments or work location 6. The schedule is posted at the beginning of the shift in a central location in each building, if applicable, accessible to staff, residents, volunteers and the public. 7. At least two (2) home health aides will be scheduled and available for residents requiring the assistance of two home health aides for scheduled and reasonably foreseeable unscheduled needs as reflected in the assessment and service plan." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 470			
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record	0 480			

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER MILES VENTS INCORPORATED			STREET ADDRESS, CITY, STATE, ZIP CODE 5817 DECATUR AVENUE NORTH NEW HOPE, MN 55428		
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0 480	Continued From page 11 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 August 6, 2024, 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			
0 640 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	0 640			

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0 640	Continued From page 12 by: Based on observation and interview, the licensee failed to support protection and safety by posting the 911 emergency number in common areas and near telephones 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: During a facility tour on August 6, 2024, at 6:48 a.m. with licensed assisted living director/registered nurse (LALD/RN)-A, the surveyor observed a facility telephone in the living room. There was no posting near the phone to call 911 in case of an emergency. LALD/RN-A stated she was unaware it was required to be posted by the facility phones. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 640			
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements:	0 680			

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0 680	Continued From page 13 (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all residents receiving services under the assisted living license. 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	0 680			

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0 680	Continued From page 14 failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On August 5, 2024, at approximately 12:00 p.m., the surveyor requested the licensee's EPP. The licensee's undated, emergency preparedness plan lacked the following required content: - two full scale community based drills in the last year - missing resident policy reviewed quarterly. The licensee's missing resident policy was dated August 1, 2021. On August 7, 2024, at 10:05 a.m. licensed assisted living director/registered nurse (LALD/RN)-A stated the facility had not participated in two full scale community based drills as required. LALD/RN-A stated she was unaware the missing resident policy needed to be reviewed quarterly. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			
0 690 SS=C	144G.43 Subdivision 1 Resident record (a) Assisted living facilities must maintain records for each resident for whom it is providing services. Entries in the resident records must be current, legible, permanently recorded, dated, and authenticated with the name and title of the person making the entry.	0 690			

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0 690	Continued From page 15 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure entries in resident records were authenticated with the name and title of the person making the entry for all five residents (R2, R3, R4, R5, R6). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R2 R2's medication administration record (MAR) for July 1-31, 2024, and August 1-6, 2024, indicated R2 received medication administration daily and an injection monthly. Staff used their initials on the MAR to document the administration. The MAR indicated "see reverse side for verifying signatures". The back side of the MAR had columns for initials, full signature, and title. Both July and August MAR's the colums were left blank. R3 R3's medication administration record (MAR) for July 1-31, 2024, and August 1-6, 2024, indicated R3 received medication administration twice a day and an injection monthly. Staff used their initials on the MAR to document the administration. The MAR indicated "see reverse side for verifying signatures". The back side of	0 690			

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0 690	Continued From page 16 the MAR had columns for initials, full signature, and title. Both July and August MAR's the columns were left blank. R4 R4's medication administration record (MAR) for July 1-31, 2024, and August 1-6, 2024, indicated R4 received medication administration three times a day. Staff used their initial on the MAR to document the administration. The MAR indicated "see reverse side for verifying signatures". The back side of the MAR had columns for initials, full signature, and title. The columns were left blank in both July and August MARs. R5 R5's MAR for July 1-31, 2024, and August 1-6, 2024, indicated R5 received medication administration of three times a day and an injection weekly. Staff used their initials on the MAR to document the administration. The MAR indicated "see reverse side for verifying signatures". The back side of the MAR had columns for initials, full signature, and title. The columns were left blank in both July and August MARs. R6 R6's MAR for July 1-31, 2024, and August 1-6, 2024, indicated R2 received medication administration twice a day. Staff used their initials on the MAR to document the administration. The MAR indicated "see reverse side for verifying signatures". The back side of the MAR had columns for initials, full signature, and title. The columns were left blank in both July and August MARs. On August 6, 2024, at 11:48 a.m. licensed assisted living director/registered nurse	0 690			

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0 690	Continued From page 17 (LALD/RN)-A stated the residents had an authentication page in their charts; however, staff had not signed them. The licensee's Clinical Records policy dated August 1, 2021, indicated "All entries into the clinical record will be legible, permanently recorded in ink, dated and authenticated with the name and title of the person making the entry." No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 690			
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the portable fire extinguishers. This deficient condition had the potential to affect all staff, residents, and visitors.	0 790			

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0 790	Continued From page 18 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On August 7, 2024, at approximately 9:45 a.m. to 10:50 a.m., survey staff conducted a facility tour with licensed assisted living director/registered nurse (LALD/RN)-A and manager (M)-C, survey staff observed that the fire extinguishers throughout the facility did not have documentation of monthly inspections. Monthly inspections of the fire extinguishers are required to ensure that all systems are maintained and remain in working order. LALD/RN-A and M-C stated they understood the requirements. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790			
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of	0 810			

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0 810	Continued From page 19 a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. 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 and provide the required training and 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	0 810			

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0 810	Continued From page 20 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 August 7, 2024, at approximately 11:30 a.m., with licensed assisted living director/registered nurse (LALD/RN)-A and manager (M)-C provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN: The FSEP (fire safety and evacuation plan) 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 plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate) but the plan was designed for a building with life safety systems such as fire doors and pull the nearest fire alarm. The policy had not been updated to provide complete actions for employees to take in the event of a fire or similar emergency at the licensed facility which did not have life safety systems or a fire-resistant construction type. 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 Drills", undated, indicated evacuation drills were conducted on January 29, 2024, June	0 810			

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0 810	Continued From page 21 28, 2024, and August 02, 2024. No other documentation was provided. TRAINING: The licensee failed to provide evacuation training to residents at least once per year. LALD/RN-A and M-C 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 August 7, 2024, at 11:30 a.m., LALD/RN-A and M-C stated they understood the areas of their policy that were incomplete and would work on bringing them into compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810			
0 830 SS=I	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, interview, and record review, the licensee failed to follow applicable state and local laws, regulations, standards, ordinances, and codes related to smoking for three of three residents (R2, R3, R4). This had the potential to affect all staff, residents, and visitors of the facility. This resulted in an immediate correction order on August 5, 2024.	0 830			

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0 830	Continued From page 22 This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On August 5, 2024, at 1:42 p.m. during the facility tour with education coordinator (EC)-D, the surveyor entered a long narrow breezeway structure through a door in the kitchen, on the other side was a wall and a door leading to the garage. Each end of the breezeway had a closed door and several closed windows. EC-D stated this was the designated smoking area for the residents. R2 was observed sitting in a chair and smoking. On August 5, 2024, at 1:50 p.m. after the facility tour, the surveyor could smell a smoke odor in the kitchen. On August 5, 2024, at 3:02 p.m. licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated R2, R3, and R4 were smokers. The licensee's contract, page 7 identified "There is no smoking in [licensee name] Assisted Living. (Resident to smoke in the smoking area)" R2 R2 was admitted to the licensee on August 14, 2023, with a diagnosis of schizophrenia, and resided on the main floor of the facility.	0 830			

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0 830	Continued From page 23 R2's contract signed August 14, 2023, included the statement "There is no smoking in [licensee name] Assisted Living. (Resident to smoke in the smoking area)". R2's Nurse Reassessment Visit dated June 26, 2024, did not include a smoking assessment. R3 R3 was admitted to the licensee on March 25, 2024, with a diagnosis of schizophrenia and resided on the main floor of the facility. R3's contract signed March 25, 2024, included the statement "There is no smoking in [licensee name] Assisted Living. (Resident to smoke in the smoking area)". R3's Nurse Reassessment Visit dated June 26, 2024, did not include a smoking assessment. R4 R4 was admitted to the licensee on October 7, 2020, with a diagnosis of schizophrenia, and resided on the main floor of the facility. R4's contract signed October 7, 2020, included the statement "There is no smoking in [licensee name] Assisted Living." R4's Nurse Reassessment Visit dated June 26, 2024, did not include a smoking assessment. On August 5, 2024, at 3:50 p.m. LALD/CNS-A stated being unaware residents could not smoke in the breezeway. LALD/CNS-A further stated there was no smoking assessment completed on any of the residents listed above.	0 830			

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0 830	Continued From page 24 On August 5, 2024, at 4:30 p.m. LALD/CNS-A stated the designated smoking area did not contain any form of mechanical ventilation system. The Minnesota Clean Indoor Air Act (MCIAA) amendment effective on August 1, 2019, noted smoking was prohibited in health care facilities and clinics. In addition, an indoor area meant a space between a floor and a ceiling that is at least half enclosed by walls, doorways, or windows (opened or closed) around the perimeter. A wall included retractable dividers, garage doors, plastic sheeting or any other temporary or permanent physical barrier. Minnesota State Statute 144.414 Prohibitions; Subdivision 3 dated 2022, indicated under a section titled Health care facilities and clinics: (a) Smoking was prohibited in any area of a hospital, health care clinic, doctor's office, licensed residential facility for children, or other health care-related facility, except that a patient or resident in a nursing home, boarding care facility, or licensed residential facility for adults may smoke in a designated separate, enclosed room maintained in accordance with applicable state and federal laws. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE The immediacy was lifted on August 7, 2024; however, the citation remains at a level 3/Widespread.	0 830			
0 900 SS=D	144G.50 Subdivision 1 Contract required	0 900			

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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
0 900	Continued From page 25 (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and execute a written contract with the required content for one of one resident (R5) prior to providing assisted living services.	0 900			

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0 900	Continued From page 26 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: R5 was admitted on June 11, 2024, with diagnoses that included schizoaffective disorder (a mental health condition that is marked by a mix of schizophrenia symptoms, such as hallucinations and delusions, and mood disorder symptoms, such as depression and mania), diabetes (a disease that affects blood sugar), and asthma (a condition in which your airways narrow and swell). R5's service plan dated June 20, 2024, indicated R5 received medication administration, blood sugar monitoring, behavior management, housekeeping and laundry assistance. R5's contract was signed on June 20, 2024. On August 6, 2024, at 10:35 a.m. licensed assisted living director/registered nurse (LALD/RN)-A stated R5 moved from another facility also owned by the licensee. LALD/RN-A stated she was unaware that R5 should have been discharged from the other facility and admitted to this facility. Contracts should be signed prior to providing care. No further information was provided.	0 900			

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0 900	Continued From page 27	0 900			
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: 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. This affected all residents residing in the facility. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The facility provided a contract included the following statements: "Insurance Liability and Release. The resident shall maintain at all times his or her own	0 970			

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0 970	Continued From page 28 health, personal property, liability, automobile (if applicable), and other insurance coverages and shall provide evidence of same by copies of binders or policies provided to [licensee name] upon request. The resident acknowledges that [licensee name] is not an insurer of the resident's person or property. The resident agrees that [licensee name] will not be liable to the resident for any personal injury or property damage (including, without limitation, damage to, or loss or theft of, automobiles or personal property of resident) suffered by the resident or the resident's agents, guests or invitees; unless and-to the extent that the injury or damage is caused by the negligence of [licensee name] or its employees or agents. The resident hereby releases [licensee name] from liability for any personal injury or property damage suffered by the resident or the resident's agents, guests, or invitees, unless caused by the negligence of [licensee name] or it's employees or agents. Indemnification: [Licensee name] shall not be liable for any damage or injury to the resident, or any other person, or to any property, occurring on the premises, or any part thereof, or in common areas thereof, and the resident agrees to hold [licensee name] harmless from any claims or damages unless caused solely by negligence of [licensee name]. It is recommended that renter's insurance be purchased at the resident's expense. Nothing contained herein is intended to create a waiver of facility liability for the health and safety or personal property of a resident." On August 6, 2024, at 11:18 a.m. licensed assisted living director/registered nurse (LALD/RN)-A stated they were unaware of the waiver of liability in the contract and they would need to update it. All contracts were the same for	0 970			

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0 970	Continued From page 29 all residents. No further information 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; (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			

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01370	Continued From page 30 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 two of two unlicensed personnel (ULP-E, ULP-F) completed training and competency evaluations in all required training topics. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-E ULP-E was hired on December 21, 2013, to provide direct care and services to the licensee's residents under the comprehensive home care license. ULP-E began providing direct care and services under the assisted living licensure on August 1, 2021. On August 6, 2024, at 7:14 a.m. ULP-E was observed administering medications to residents. ULP-E's employee record lacked evidence of	01370			

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01370	Continued From page 31 completed training and/or competency for the following: (2) reports of changes in the resident's condition to the supervisor designated by the facility; (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; (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; (13) understanding appropriate boundaries between staff and residents and the resident's family; and (15) awareness of commonly used health technology equipment and assistive devices. On August 7, 2024, at 1:30 p.m. education coordinator (EC)-D stated the electronic training system was new to the facility and some items had been assigned to ULP-E, but they had not been completed. ULP-F ULP-F was hired on April 25, 2024, to provide direct care and services to the facility's residents. On August 6, 2024, at 6:34 a.m. upon surveyor arrival at the facility, ULP-F was observed working independently in the facility.	01370			

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01370	Continued From page 32 ULP-F's record identified he had completed training November and December 2023, while working for a different assisted living. ULP-F's record lacked evidence the following competency testing had been completed: (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; (7) standby assistance techniques and how to perform them; On August 7, 2024, at 2:45 p.m. EC-D stated since he had the training within 18 months of hire he did not have ULP-F complete the training. EC-D stated he was unaware the practical skills competencies was not portable. No further information was 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	01380			

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01380	Continued From page 33 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: Based on observation, interview, and record review, the licensee failed to ensure two of two unlicensed personnel (ULP-E, ULP-F) completed training and competency evaluations in all required training topics. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-E was hired on December 21, 2013, to provide direct care and services to the licensee's residents under the comprehensive home care license. ULP-E began providing direct care and services under the assisted living licensure on August 1, 2021. On August 6, 2024, at 7:14 a.m. ULP-E was observed administering medications to residents.	01380			

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01380	Continued From page 34 ULP-E's employee record lacked evidence of completed training and/or competency for the following: (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. On August 7, 2024, at 1:30 p.m. education coordinator (EC)-D stated the electronic training system was new to the facility and some items had been assigned to ULP-E, but they had not yet been completed. ULP-F ULP-F was hired on April 25, 2024, to provide direct care and services to the facility's residents. On August 6, 2024, at 6:34 a.m. upon surveyor arrival at the facility, ULP-F was observed working independently in the facility. ULP-F's record identified he had completed training November and December 2023, while working for a different assisted living. ULP-F's record lacked evidence the following competency testing had been completed: (3) reading and recording temperature, pulse, and respirations of the resident;	01380			

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01380	Continued From page 35 (5) safe transfer techniques and ambulation; and (6) range of motioning and positioning. On August 7, 2024, at 2:45 p.m. EC-D stated since he had the training within 18 months of hire, he did not have ULP-F complete the training. EC-D stated he was unaware that practical skills competencies was not portable. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380			
01470 SS=D	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints;	01470			

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01470	Continued From page 36 (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation 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 the challenges it poses to communication; (2) 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 one of two employees (unlicensed personnel (ULP)-F) received orientation to assisted living facility licensing requirements and regulations before providing services.	01470			

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01470	Continued From page 37 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-F was hired on April 25, 2024, to provide direct care and services to the facility's residents. On August 6, 2024, at 6:34 a.m. upon surveyor arrival at the facility, ULP-F was observed working independently in the facility. ULP-F's record identified he had completed training November and December 2023, while working for a different assisted living. On August 7, 2024, at 2:45 p.m. education coordinator (EC)-D stated since he had the training within 18 months of hire, he did not have ULP-F complete the training. EC-D stated he was unaware that orientation for staff was not portable. The licensee's Staff Orientation and Education policy dated August 1, 2021, indicated "Upon hire and before providing service to residents, all employees attend a general orientation conducted by [licensee name]. Those providing direct services will complete a competency evaluation as part of the orientation process." No further information was provided.	01470			

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01470	Continued From page 38	01470			
01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct	01500			

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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
01500	Continued From page 39 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 all employees had at least eight hours of annual training for each 12 months of employment that included the required content for one of one unlicensed personnel (ULP-E). 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			

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01500	Continued From page 40 situation has occurred only occasionally). The findings include: ULP-E was hired on December 21, 2013, to provide direct care and services to the licensee's residents under the comprehensive home care license. ULP-E began providing direct care and services under the assisted living licensure on August 1, 2021. On August 6, 2024, at 7:14 a.m. ULP-E was observed administering medications to residents. ULP-E's employee record indicated ULP-E had four hours of training in the last year, and ULP-E's annual training failed to include the following required topics: - Infection control techniques - Effective approaches to use to problems solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer ' s disease, or related disorders - Review of provider's policies and procedures - Principles of person-centered planning/service delivery On August 7, 2024, at 1:30 p.m. education coordinator (EC)-D stated the electronic training system was new to the facility and some items had been assigned to ULP-E, but they had not yet been completed. The licensee's Staff Orientation and Education policy dated August 1, 2021, indicated "14. Annual education may include training on providing services to residents with hearing loss. This training will be research-based and include: a. An explanation of age-related hearing loss	01500			

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01500	Continued From page 41 and how it manifests itself, its prevalence and the challenges it poses to communication; b. Health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation and depression c. 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". No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500			
01530 SS=D	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	01530			

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01530	Continued From page 42 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 observation, interview, and record review, the licensee failed to ensure one of one employee (unlicensed personnel (ULP)-E) had two hours of dementia care training annually. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-E was hired on December 21, 2033, to provide direct care and services to the licensee's residents under the comprehensive home care license. ULP-E began providing direct care and services under the assisted living licensure on August 1, 2021. On August 6, 2024, at 7:14 a.m. ULP-E was observed administering medications to residents. ULP-E's employee record lacked evidence ULP-E had completed two hours of dementia training in	01530			

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01530	Continued From page 43 the last year. On August 27, 2024, at 1:30 p.m. education coordinator (EC)-D stated the electronic training system was new to the facility and some items had been assigned to ULP-E, but they had not yet been completed. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530			
01610 SS=D	144G.70 Subd. 2 (a-b) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a registered	01610			

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01610	Continued From page 44 nurse (RN) conducted an initial nursing assessment of the physical and cognitive needs for one of one resident (R5) prior to or on the date of admission. 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 August 6, 2024, at 7:14 a.m. ULP-E was observed administering medications to R5. R5 was admitted on June 11, 2024, with diagnoses that included schizoaffective disorder (a mental health condition that is marked by a mix of schizophrenia symptoms, such as hallucinations and delusions, and mood disorder symptoms, such as depression and mania), diabetes (a disease that affects blood sugar), and asthma (a condition in which your airways narrow and swell). R5's service plan dated June 20, 2024, indicated R5 received medication administration, blood sugar monitoring, behavior management, housekeeping and laundry assistance. R5's record included a Resident Evaluation assessment dated June 20, 2024, which was nine days after R5 was admitted. On August 6, 2024, at 10:35 a.m. licensed	01610			

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01610	Continued From page 45 assisted living director/registered nurse (LALD/RN)-A stated R5 "transferred" from another facility also owned by the licensee. LALD/RN-A stated she was unaware that R5 should have been discharged from the other facility and admitted to this facility; therefore, an initial assessment was not completed prior to or on the date of admission. The licensee's Assessment and Reassessment policy dated August 1, 2021, indicated "The initial RN assessment shall be completed prior to the date on which the prospective resident executes a contract or on the date on which the prospective resident moves in, whichever is earlier. If necessary, based on geography or urgent or unexpected circumstances, the assessment may be conducted via telecommunications based on practice standards that meet the resident 's needs and reflect person-centered planning and care delivery." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01610			
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision	01620			

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01620	Continued From page 46 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. 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 a 14-day assessment for two of three residents (R2, R3) and failed to complete a comprehensive assessment every 90 days as required for three of three residents (R2, R3, R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: R2 R2 was admitted to the facility on August 14, 2023.	01620			

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01620	Continued From page 47 On August 6, 2024, at 8:00 a.m. unlicensed personnel (ULP)-E was observed administering medications to R2 R2's service plan dated August 14, 2024, indicated R2 received services including behavior management, medication management, and medication administration. R2's record identified the following assessments: - a Resident Evaluation dated August 14, 2023 (initial assessment); - a Nurse Reassessment Visit dated January 24, 2024, this was 163 days between assessments instead of 90 days as required; - a Nurse Reassessment Visit dated March 12, 2024; and - a Nurse Reassessment Visit dated June 26, 2024, this was 106 days between assessments. R2's record lacked a 14 day assessment, and the January 24, 2024, and June 26, 2024 assessments were not completed timely. In addition, the Nurse Reassessment Visit form did not include all assessment information required in the uniform assessment tool. R3 R3 was admitted on March 25, 2024. R3's service plan dated March 25, 2024, indicated R3 received services including behavior management, medication management, and medication administration. R3's record indicated the following assessments: - Pre-Screening of Potential Resident Needs dated March 25, 2024 (initial assessment); - Nurse Reassessment Visit dated April 9, 2024, this was 15 days after the initial assessment and	01620			

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01620	Continued From page 48 exceeded 14 days as required; and - Nurse Reassessment Visit dated June 26, 2024. In addition, the Nurse Reassessment Visit form did not include all assessment information required in the uniform assessment tool. R4 R4 was admitted on October 7, 2020. On August 6, 2024, at 7:15 a.m. ULP-E was observed administering medications to R4. R4's record identified the following assessments: - Nurse Reassessment Visit dated March 12, 2024; and - Nurse Reassessment Visit dated June 26, 2024, this was 106 days after the last assessment and exceed 90 days as required. In addition, the Nurse Reassessment Visit form did not include all assessment information required in the uniform assessment tool. On August 6, 2024, at 10:35 a.m. licensed assisted living director/registered nurse (LALD/RN)-A stated assessments should have been completed on admission, 14-days and every 90 days as required. LALD/RN-A stated she was unaware the Nurse Reassessment Visit form used by the licensee did not contain all areas required in the uniform assessment tool. The licensee's Assessment and Reassessment policy dated August 1, 2021, indicated "Ongoing resident reassessments must be conducted by an RN and cannot exceed 90 days from the last date of assessment." The licensee's Comprehensive Nursing Assessment policy dated August 1, 2021, identified the following:	01620			

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01620	Continued From page 49 "1. The RN will conduct a comprehensive assessment utilizing a uniform assessment tool that addresses the following: a. Head to Toe Evaluation i. Current Medical and Nursing Diagnoses/Health Conditions ii. Communication and Sensory Capabilities 1. Hearing 2. Vision 3. Speech 4. Assistive Communication and Sensory Devices, including a. Hearing Aids b. The Ability to Understand and be Understood iii. Activities of Daily Living iv. Instrumental Activities of Daily Living v. Skin/Integument Status vi. Digestive/Nutritional Status, including 1. Hydration 2. Diet 3. Food Allergies 4. Weight vii. Respiratory Status 1. Seasonal Allergies viii. Urinary Status ix. Joint/Muscle Status x. Endocrine xi. Cardiovascular, including 1. Vital Signs xii. Neurological Status xiii. Pain, including 1. Location, Frequency, Intensity and Duration 2. Effectiveness of Medications and Nonmedication Interventions xiv. Infectious Conditions xv. Mental/Emotional Health, including 1. Cognition, including a. Review of Neurocognitive Evaluations	01620			

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01620	Continued From page 50 and Diagnoses b. Current Memory, Orientation, Confusion and Decision-Making Status and Ability 2. History/Diagnoses of Mood Disorders, such as a. Depression b. Anxiety c. Bipolar Disorder d. Thought or Behavioral Disorders 3. Current Symptoms of Mental Health Conditions and Behavioral Expressions of Concern 4. Effective Medication Treatment and Nonmedication Interventions xvi. Psychological Status, including Losses xvii. Lifestyle Preferences, including 1. Social Supports/Needs 2. Sleep schedule 3. Leisure Activities 4. Prior Housing Situation(s) 5. Smoking, including Safety Factors 6. Alcohol/Drug Use (nonprescribed) xviii. Spiritual Assessment xix. Cultural Assessment xx. Safety Factors xxi. Health History, including: 1. Access of Health Care over Past 12 Months, including a. Medical Visits (PCP) b. Hospitalizations c. Surgeries d. Post-Acute In-Patient Care e. Dental Visits f. Emergency Room Visits 2. Reports from Physical Therapy, Occupational Therapy, Speech Therapy or Cognitive Evaluations within Past 12 Months b. Vulnerability Assessment, including Risk for Elopement c. Falls Risk Assessment	01620			

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01620	Continued From page 51 d. SLUMS (if appropriate) e. Nutritional Assessment (if appropriate) f. Medications* i. Medication Allergies g. Emergency Information, including Evacuation Level** h. End of Life Preferences, including i. Health Care Directives ii. "DNR/DNI" orders iii. POLST 2. To determine the care plan needs for the resident, the RN will assess the following: a. Current treatments the resident requires, including the type, frequency and level of assistance needed b. Nursing needs, including the potential to receive nursing-delegated services 3. The RN will assess who has decision-making authority for the resident, including power of attorney and other legal documents establishing a substitute decision maker as well as the scope of decision-making. 4. Based on the assessment, the RN will work with the resident/responsible party to prepare an individualized home health aide care plan addressing the home care services needed. 5. As part of the assessment, the RN evaluates any abnormalities in the skin, including, but not limited to redness, cyanosis or discoloration; open areas, including wounds, ulcers, skin breakdown and cuts; bruising; rashes; dryness or other irregularities. If appropriate, the RN may use a standardized skin assessment tool (Braden Scale). a. Based on the assessment, the RN delegates skin care to the home health aides. b. The RN will identify skin care interventions on the care plan, including, but not limited to: i. Hygiene measures ii. Application of lotion	01620			

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01620	Continued From page 52 iii. Physician ordered treatments iv. Repositioning v. Monitoring for changes or new symptoms vi. Observations to report to the RN 6. The RN will reassess the integument system as part of the reassessment visits***."	01620			
01650 SS=D	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and	01650			

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01650	Continued From page 53 (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the service plan included all required content for one of one resident (R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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 August 6, 2024, at 7:14 a.m. unlicensed personnel (ULP)-E was observed administering medications to R5. R5 was admitted on June 11, 2024, with diagnoses that included schizoaffective disorder (a mental health condition that is marked by a mix of schizophrenia symptoms, such as hallucinations and delusions, and mood disorder symptoms, such as depression and mania), diabetes (a disease that affects blood sugar), and asthma (a condition in which your airways narrow and swell). R5's service plan dated June 20, 2024, indicated	01650			

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NAME OF PROVIDER OR SUPPLIER MILES VENTS INCORPORATED			STREET ADDRESS, CITY, STATE, ZIP CODE 5817 DECATUR 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
01650	Continued From page 54 R5 received medication administration, blood sugar monitoring, behavior management, housekeeping and laundry assistance. The service plan failed to identify the identification of staff or categories of staff who will provide the services. On August 7, 2021, at 11:01 a.m. licensed assisted living director/registered nurse (LALD/RN)-A stated service plans should have included all required content The licensee's Service Plan policy dated August 1, 2021, indicated "8. The service plan includes the following: c. The identification of the staff or categories of staff who will provide the services" No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	01650			
01700 SS=F	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and	01700			

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01700	Continued From page 55 identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. 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 a face-to-face medication management assessment to include all required content for three of three residents (R2, R3, R5) receiving 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) 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: R2 On August 6, 2024, at 8:00 a.m. unlicensed personnel (ULP)-E was observed administering	01700			

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01700	Continued From page 56 medications to R2. R2 was admitted on August 14, 2023, with diagnoses that included alcohol use disorder schizophrenia (a serious mental health condition that affects how people think, feel and behave) and bipolar disorder (a mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration). R2's service plan dated August 14, 2023, indicated R2 services included medication management and medication administration. R2's August 1-6, 2024, medication administration record (MAR) indicated R2 received the following medications: - Vitamin D3 (supplement) 25 mcg (micrograms) take 1 capsule by mouth once daily - Invega Sustenna (antipsychotic) 234 mg (milligrams)/1.5 ml (milliliters) inject one syringe intramuscularly every four weeks. R2's record included a Resident Evaluation assessment dated August 14, 2023, which indicated R2 received medication administration. The assessment failed to include: - interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications; and - identification and review of all medications the resident is known to be taking including indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues.	01700			

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01700	Continued From page 57 R3 On August 6, 2024, at 9:30 a.m. ULP-E was observed administering medications to R3. R3 was admitted on March 25, 2024, with a diagnosis of schizophrenia. R3's service plan dated March 28, 2024, indicated R3 received medication management and medication administration. R3's August 1-6, 2024, MAR indicated R3 received the following medications: - benztropine (stops severe muscle spasms of the back, neck, and eyes that are sometimes caused by psychiatric medications) 0.5 mg take one tablet by mouth twice daily - olanzapine (antipsychotic) 25 mg take two tablets by mouth at bedtime - risperidone (antipsychotic) 4 mg take one tablet by mouth at bedtime - Invega Sustenna 234 mg/1.5 ml inject one syringe intramuscularly every four weeks. R3's record included a Resident Evaluation assessment dated March 29, 2024, which indicated R3 received medication administration. The assessment failed to include: - identification and review of all medications the resident is known to be taking including indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. R5 On August 6, 2024, at 7:14 a.m. ULP-E was observed administering medications to R5. R5 was admitted on June 11, 2024, with	01700			

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01700	Continued From page 58 diagnoses that included schizoaffective disorder (a mental health condition that is marked by a mix of schizophrenia symptoms, such as hallucinations and delusions, and mood disorder symptoms, such as depression and mania), diabetes (a disease that affects blood sugar), and asthma (a condition in which your airways narrow and swell). R5's service plan dated June 20, 2024, indicated R5 received medication administration, blood sugar monitoring, behavior management, housekeeping and laundry assistance. R5's August 1-6, 2024, MAR indicated R5 received the following medications: - aspirin (heart) 81 mg chew one tablet by mouth daily - divalproex (seizure medication also used as a mood stabilizer) 500 mg ER take two tablets by mouth daily - furosemide (diuretic) 20 mg take one tablet by mouth daily - glipizide (diabetes) 5 mg take one tablet by mouth once daily - Jardiance (diabetes) 25 mg take one tablet by mouth once daily - lisinopril (blood pressure) 30 mg take one tablet by mouth once daily - Singulair (asthma) 10 mg take one tablet by mouth at bedtime - omeprazole (gastric reflux) 20 mg take one capsule by mouth once daily - polyethylene glycol (constipation) mix one packet with liquid and drink once daily - vitamin D3 (supplement) 25 mcg take four tablets by mouth once daily - metformin (diabetes) 1000 mg take one tablet by mouth twice daily - carvedilol (heart) 3.125 mg take one tablet by	01700			

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01700	Continued From page 59 mouth twice daily - haloperidol (antipsychotic) 5 mg take one tablet by mouth twice daily - atorvastatin (cholesterol) 40 mg take one tablet by mouth at bedtime - divalproex 500 mg take three tablets at bedtime - prazosin (nightmares) 2 mg take one capsule by mouth at bedtime - Trulicity (diabetes) 1.5 mg/0.5 ml inject 0.5 ml once weekly for diabetes. R5's record included a Resident Evaluation assessment dated June 20, 2024, which indicated R5 received medication administration. The assessment failed to include: - identification and review of all medications the resident is known to be taking including indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. On August 7, 2024, at 11:01 a.m. licensed assisted living director/registered nurse (LALD/RN)-A stated she believed they were looking at indication, side effects, and contraindications, but they were not documented. The licensee's Assessment of Medications policy dated August 1, 2021, identified "Prior to providing medication management services, [licensee name] will provide an assessment by a registered nurse (RN) to determine what medication management services will be provided and how they will be implemented. Procedure: 1. The RN will provide and document a face-to-face assessment with the resident. 2. The assessment includes the following elements. a. Identification of all medications, including	01700			

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01700	Continued From page 60 over-the-counter and herbal/dietary supplements b. Medication reconciliation i. Identification of the most accurate list of all medications the resident is taking, including the name, dosage, frequency and route by comparing the resident record to an external list of medications obtained from the resident, hospital, prescriber of other provider ii. Assessment of the following: 1. Indication for medications 2. Effectiveness of drug therapy 3. Side effects 4. Immediate desired effects 5. Unusual and unexpected effects 6. Actual or potential drug interactions 7. Duplicate drug therapy 8. Non-adherence with drug therapy 9. Drug therapy currently associated with laboratory monitoring 10. Allergic reactions 11. Changes in condition that contraindicate continued administration of the medication 12. Any difficulties with taking the medication 13. Resident preferences in how to take medications c. Interventions needed in management of medications to prevent the potential for diversion of medications by the resident or others with access to it. The resident and resident ' s legal or designated representatives will be educated regarding interventions to manage the medications and prevent diversion. The risk (high, moderate or low risk) for diversion will be measured according to the following criteria i. Controlled substances being used by resident ii. Presence of other residents or visitors to	01700			

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01700	Continued From page 61 home with access to medications iii. Other risk factors/lack of protection of medications" No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01700			
01710 SS=F	144G.71 Subd. 3 Individualized medication monitoring and reas The assisted living facility must monitor and reassess the resident's medication management services as needed under subdivision 2 when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually. 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 an annual reassessment of the resident's medication management services for the licensee's one resident who had lived at the facility more than a year (R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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:	01710			

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01710	Continued From page 62 On August 6, 2024, at 7:14 a.m. unlicensed personnel (ULP)-E was observed administering medications to R4. R4 was admitted on October 7, 2020, with diagnosis of schizophrenia (a serious mental health condition that affects how people think, feel and behave). R4's service plan dated October 7, 2020, indicated R4 received medication administration services. R4's Home Care Assessment dated October 26, 2020, indicated R4 received medication administration. R4's Nurse Reassessment Visit dated June 26, 2024, indicated the following check marked: - reconciliation - plan reviewed with resident - plan appropriate to resident needs. R4's record lacked evidence an annual medication assessment had been completed. On August 7, 2024, at 10:35 a.m. licensed assisted living director/registered nurse (LALD/RN)-A stated she was unaware the Nurse Reassessment Visit form did not contain all the required content. The licensee's Assessment of Medications policy dated August 1, 2021, identified "Prior to providing medication management services, [licensee name] will provide an assessment by a registered nurse (RN) to determine what medication management services will be provided and how they will be implemented.	01710			

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01710	Continued From page 63 Procedure: 1. The RN will provide and document a face-to-face assessment with the resident. 2. The assessment includes the following elements. a. Identification of all medications, including over-the-counter and herbal/dietary supplements b. Medication reconciliation i. Identification of the most accurate list of all medications the resident is taking, including the name, dosage, frequency and route by comparing the resident record to an external list of medications obtained from the resident, hospital, prescriber of other provider ii. Assessment of the following: 1. Indication for medications 2. Effectiveness of drug therapy 3. Side effects 4. Immediate desired effects 5. Unusual and unexpected effects 6. Actual or potential drug interactions 7. Duplicate drug therapy 8. Non-adherence with drug therapy 9. Drug therapy currently associated with laboratory monitoring 10. Allergic reactions 11. Changes in condition that contraindicate continued administration of the medication 12. Any difficulties with taking the medication 13. Resident preferences in how to take medications c. Interventions needed in management of medications to prevent the potential for diversion of medications by the resident or others with access to it. The resident and resident's legal or designated representatives will be educated regarding interventions to manage the	01710			

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01710	Continued From page 64 medications and prevent diversion. The risk (high, moderate or low risk) for diversion will be measured according to the following criteria i. Controlled substances being used by resident ii. Presence of other residents or visitors to home with access to medications iii. Other risk factors/lack of protection of medications d. Medication reassessment will occur at the following times i. Resident symptomology ii. Problems or concerns that may be medication-related iii. With new prescription, OTC or herbal products iv. Annually" No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01710			
01730 SS=D	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	01730			

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01730	Continued From page 65 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: Based on observation, interview, and record review, the licensee failed to develop and implement a current individualized medication management plan to include all required content for one of four residents (R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	01730			

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01730	Continued From page 66 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 August 6, 2024, at 7:14 a.m. unlicensed personnel (ULP)-E was observed administering medications to R5. R5 was admitted on June 11, 2024, with diagnoses that included schizoaffective disorder (a mental health condition that is marked by a mix of schizophrenia symptoms, such as hallucinations and delusions, and mood disorder symptoms, such as depression and mania), diabetes (a disease that affects blood sugar), and asthma (a condition in which your airways narrow and swell). R5's service plan dated June 20, 2024, included the following: - medication set up weekly; - medication administration daily; and - monitoring (includes supplies/ordering) continually. The medication plan failed to identify: - persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; and - medication management tasks that may be delegated to unlicensed personnel. R5's August 1-6, 2024, medication administration record (MAR) indicated R5 received the following medications: - aspirin (heart) 81 mg (milligrams) chew one	01730			

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01730	Continued From page 67 tablet by mouth daily - divalproex (seizure medication also used as a mood stabilizer) 500 mg ER take two tablets by mouth daily - furosemide (diuretic) 20 mg take one tablet by mouth daily - glipizide (diabetes) 5 mg take one tablet by mouth once daily - Jardiance (diabetes) 25 mg take one tablet by mouth once daily - lisinopril (blood pressure) 30 mg take one tablet by mouth once daily - Singulair (asthma) 10 mg take one tablet by mouth at bedtime - omeprazole (gastric reflux) 20 mg take one capsule by mouth once daily - polyethylene glycol (constipation) mix one packet with liquid and drink once daily - vitamin D3 (supplement) 25 mcg (micrograms) take four tablets by mouth once daily - metformin (diabetes) 1000 mg take one tablet by mouth twice daily - carvedilol (heart) 3.125 mg take one tablet by mouth twice daily - haloperidol (antipsychotic) 5 mg take one tablet by mouth twice daily - atorvastatin (cholesterol) 40 mg take one tablet by mouth at bedtime - divalproex 500 mg take three tablets at bedtime - prazosin (nightmares) 2 mg take one capsule by mouth at bedtime - Trulicity (diabetes) 1.5 mg/0.5 ml (milliliters) inject 0.5 ml once weekly for diabetes. On August 7, 2021, at 11:01 a.m., licensed assisted living director/registered nurse (LALD/RN)-A stated the medication plan should have had all the required content. The licensee's Assessment of Medications dated	01730			

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01730	Continued From page 68 August 1, 2024, identified "Based on the results of the assessment, the RN will document an individualized medication management plan, including the following: - Identification of person(s) responsible for monitoring medication supplies and ensuring refills are ordered in a timely manner - Identification of medication management tasks delegated to unlicensed staff" No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730			
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 ordered for one of five residents (R5) and failed to ensure medications	01760			

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01760	Continued From page 69 were documented as administered or not administered for all five residents (R5, R2, R3, R4, R6). 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: R5 On August 6, 2024, at 7:14 a.m. the surveyor observed unlicensed personnel (ULP)-E administer medications to R5. ULP-E removed a medication caddy that contained oral medications, poured the medications into a medication cup and administered them to R5. R5 took the medication with a bottle of water he had at his bedside. ULP-E documented medication administration which included polyethylene glycol (used for constipation) mix one packet with liquid and drink by mouth every morning; however, polyethylene glycol was not observed to be administered. R5's service plan dated June 20, 2024, indicated R5 received medication administration services. R5's physician orders dated May 8, 2024, included an order for polyethylene glycol mix one packet with liquid and drink by mouth every morning. On August 7, 2024, at 9:20 a.m. licensed assisted living director/registered nurse (LALD/RN)-A	01760			

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01760	Continued From page 70 checked medication cabinet and stated there was not any polyethylene glycol in the cabinet and it would have to be reordered. LALD/RN-A stated staff should not have documented they administered the polyethylene glycol if they did not administer it. In addition, R5's medication administration record (MAR) for August 1-6, 2024, identified the following: *August 2, 2024, August 3, 2024, and August 5, 2024, at 8:00 a.m. one or more of the following medications were not documented as administered or refused: - aspirin (heart health) - divalproex (seizure medication also used as a mood stabilizer) - furosemide (fluid retention) - glipizide (diabetes) - Jardiance (diabetes) - lisinopril (blood pressure) - montelukast (asthma) - omeprazole (gastric reflux) - polyethylene glycol - vitamin D3 - metformin (diabetes) - carvedilol (heart) - haloperidol (antipsychotic) *August 2, 2024, and August 5, 2024, at 8 p.m. the following medications were not documented as administered or refused: - metformin - carvedilol - haloperidol - atorvastatin (cholesterol) - divalproex - prazosin (nightmares) R2 On August 6, 2024, at 8:00 a.m. ULP-E was	01760			

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01760	Continued From page 71 observed administering medications to R2. R2's unsigned, service plan dated August 2023, identified R2 received medication administration services. R2's MAR for August 1-6, 2024, identified the following: *August 3, 2024, at 8:00 a.m. the following medications were not documented as administered or refused: - vitamin D3 R3 On August 6, 2024, at 9:30 a.m. ULP-E was observed administering medications to R3. R3's service plan dated March 25, 2024, identified R3 received medication administration services. R3's MAR for August 1-6, 2024, identified the following: *August 3, 2024, and August 4, 2024, at 8:00 a.m. the following medications were not documented as administered or refused: - benztropine (stop severe muscle spasms of the back, neck, and eyes that are sometimes caused by psychiatric drugs) *August 2, 2024, August 4, 2024, and August 5, 2024, at hour of sleep (HS) the following medications were not documented as administered or refused: - benztropine - olanzapine (schizophrenia) - risperidone (antipsychotic) R4 On August 6, 2024, at 7:30 a.m. ULP-E was observed administering medications to R4.	01760			

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01760	Continued From page 72 R4's service plan dated October 7, 2020, identified R4 received medication administration services. R4's MAR for August 1-6, 2024, identified the following: *August 2, 2024 and August 3, 2024, August 4, 2024, August, 5, 2024, and August 6, 2024, at 8:00 a.m. one or more of the following medications were not documented as administered or refused: - amlodipine (heart) - aripiprazole (antipsychotic) - atorvastatin - multivitamin - fluoxetine (antidepressant) - polyethylene glycol - ketoconazole (antifungal) - lisinopril - metoprolol (blood pressure) - oxybutynin (overactive bladder) - Senexon-S (constipation) - calcium with vitamin D - chlorhexidine (gingivitis) - fiberlax (bowel regulation) - nystatin powder (antifungal) - gabapentin (seizure medication also used as a mood stabilizer and for pain) *August 2, 2024 and August 3, 2024, August 4, 2024, August, 5, 2024, and August 6, 2024, at 12:00 p.m. the following medications were not documented as administered or refused: - gabapentin *August 2, 2024 and August 3, 2024, August 4, 2024, August, 5, 2024, and August 6, 2024, at 8:00 p.m. one or more of the following medications were not documented as administered or refused: - Senoxen-S	01760			

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01760	Continued From page 73 - calcium with vitamin D - chlorhexidine - fiberlax - nystatin powder - gabapentin - dentagel (prevent cavities, tooth decay, and gum disease) - trazadone (antidepressant) R6 On August 6, 2024, at 7:20 a.m. ULP-E was observed administering medications to R6. R6's MAR for August 1-6, 2024, identified the following: *August 3, 2024, the following medication was not documented as administered or refused: - amlodipine On August 7, 2024, at 9:20 a.m. LALD/RN-A stated all medications should be documented as administered or not administered, along with a reason why they were not administered. The licensee's Medication Documentation policy dated August 1, 2021, identified "Each medication administered by [licensee name] staff will be documented in the resident's clinical record. Documentation will be complete, accurate and legible." No further information 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	01880			

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01880	Continued From page 74 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 one of one medication cart was securely locked in substantially constructed compartments and permitted only authorized personnel to have access. This had the potential to affect all residents residing in 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: On August 5, 2024, at 2:45 p.m. unlicensed personal (ULP)-E removed a set of keys from an unlocked desk drawer in the kitchen, and used the keys to unlock a file cabinet where the medications were stored, removed R3's medications from the drawer and left the room with the drawer open and the cabinet unlocked. R3 walked through the dining room. The cabinet was not visible to ULP-E. At 2:53 p.m., ULP-E returned to the kitchen and shut the file cabinet drawer and locked the cabinet. On August 5, 2024, from 3:24 p.m. until 4:43 p.m. the surveyor observed the file cabinet to be	01880			

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01880	Continued From page 75 unlocked. During this time, multiple staff and residents were walking in and out of the room. On August 6, 2024, at 9:30 a.m. the surveyor observed ULP-E unlock the cabinet and remove a book, completed documentation, and returned the book to the file cabinet. ULP-E did not lock the cabinet. The surveyor continuously observed the unlocked file cabinet until 12:44 p.m. During the observation, multiple staff, including a maintenance person, ULP-E, and licensed assisted living director/registered nurse (LALD)-A, were noted entering and exiting the room. In addition, multiple residents were noted entering and leaving the room, at times with no staff present. At 12:44 p.m., ULP-E locked the cabinet. On August 7, 2024, at 2:45 p.m. LALD/RN-A stated the medication file cabinet should be locked at all times when staff were not present. The licensee's Storage/Control of Medications policy dated August 1, 2021, identified "When [licensee name] is providing storage of medications outside of the resident's private living space, all prescription drugs are securely locked in substantially constructed compartments according to the manufacturer's directions. Only authorized personnel have access to the stored medications." No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880			
01910 SS=F	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by	01910			

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01910	Continued From page 76 the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document the disposition of medications for one of one discharged resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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's record included a Discharge Summary dated	01910			

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01910	Continued From page 77 April 1, 2024, which indicated R1 received medication management services while residing at the facility. A document titled Medications Given to Resident on Discharge dated March 29, 2024, identified medications that were given to R1 and included the name of the drug, the dosage, the directions, and the number of medications given. The document failed to include the prescription number for the medications. On August 6, 2024, at 8:21 a.m. licensed assisted living director/registered nurse (LALD/RN)-A stated she was unaware the disposition of medications required the prescription number for the medications. The licensee's Disposition and Disposal of Medications policy dated August 1, 2021, identified "Upon disposition, [licensee name] will document the following information in the clinical record - Name, strength and prescription number of medication, as applicable" No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910			
01940 SS=F	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services	01940			

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01940	Continued From page 78 that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for the licensee's one resident (R5) receiving treatments. 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	01940			

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01940	Continued From page 79 or has the potential to affect a large portion or all of the residents). The findings include: On August 6, 2024, at 7:14 a.m. the surveyor observed unlicensed personnel (ULP)-E assisting R5 to check his blood sugar. R5's diagnoses included diabetes. R5's prescriber orders dated May 3, 2024, included orders to check blood sugar twice a day. R5's Service Plan dated June 20, 2024, indicated R5 received blood sugar checks twice a day. R5's Diabetic Flow Sheet indicated blood sugar monitoring had been completed by ULP. R5's record lacked a treatment management plan to include the following required content: - procedures for notifying a registered nurse when a problem arose with treatments or therapy services. On August 7, 2024, at 11:01 a.m. licensed assisted living director/registered nurse (LALD/RN)-A stated R5's record lacked a treatment management plan to include all the required content as noted above. LALD/RN-A stated there should be blood sugar parameters, so staff know when to notify the nurse. The licensee's Treatment and Therapy Management policy dated August 1, 2021, identified "The RN or licensed professional will prepare an individualized treatment or therapy management plan for each resident receiving ordered or prescribed treatments or therapy	01940			

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01940	Continued From page 80 services, which addresses: - Procedures for notifying the RN or licensed health professional when a problem arises related to the treatment or therapy service." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940			
01950 SS=D	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident 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 record; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of one unlicensed personnel (ULP-E) completed competency evaluations for blood glucose	01950			

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01950	Continued From page 81 monitoring. 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 August 6, 2024, at 7:14 a.m. the surveyor observed ULP-E assist R5 to check his blood sugar. ULP-E was hired on December 21, 2013, under the licensee's Comprehensive Home Care license, and began providing services under the licensee's Assisted Living Licensure on August 1, 2021. ULP-E's employee file identified she had completed an electronic training course for blood glucose monitoring on February 12, 2024; however, ULP-E's file lacked evidence a practical skills competency had been completed. On August 7, 2024, at 2:45 p.m. education coordinator (EC)-D stated the licensee had no further documentation of competencies for ULP-E, and a competency evaluation for blood glucose monitoring should have been completed. The licensee's Staff Competency policy dated August 1, 2021, indicated staff would be competency tested for all delegated tasks.	01950			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37091	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/07/2024
NAME OF PROVIDER OR SUPPLIER MILES VENTS INCORPORATED		STREET ADDRESS, CITY, STATE, ZIP CODE 5817 DECATUR 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
01950	Continued From page 82 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950			
01960 SS=F	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure blood glucose monitoring was documented as completed or refused for the licensee's one resident (R5) receiving treatments. 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:	01960			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37091	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/07/2024
NAME OF PROVIDER OR SUPPLIER MILES VENTS INCORPORATED			STREET ADDRESS, CITY, STATE, ZIP CODE 5817 DECATUR AVENUE NORTH NEW HOPE, MN 55428		
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01960	Continued From page 83 On August 6, 2024, at 7:14 a.m. the surveyor observed unlicensed personnel (ULP)-E assisting R5 to check his blood sugar. R5's diagnoses included diabetes. R5's prescriber orders dated May 3, 2024, included orders to check blood sugar twice a day. R5's Service Plan dated June 20, 2024, indicated R5 received blood sugar checks twice a day. R5's Diabetic Flow Sheet included blood sugar monitoring instructions "blood sugar checked twice". The flow sheet included date, time, blood sugar result, and staff initials. The flow sheet lacked documentation the blood sugar had been checked August 2, 2024, August 3, 2024, and only one time on August 5, 2024. On August 7, 2024, at 11:01 a.m. licensed assisted living director/registered nurse (LALD/RN)-A stated staff should be completing blood glucose monitoring twice daily and it should have been documented. The licensee's Treatment and Therapy Management policy dated August 1, 2021, identified the following: "7. Each staff member who administers a treatment or therapy is responsible for documenting this in the clinical record. 8. When a treatment or therapy is not administered as ordered or prescribed, staff will document the reason why it was not administered and any follow-up procedures provided to meet the resident's needs as documented in the care plan or treatment plan or as ordered by the authorized prescriber."	01960			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37091	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/07/2024
NAME OF PROVIDER OR SUPPLIER MILES VENTS INCORPORATED		STREET ADDRESS, CITY, STATE, ZIP CODE 5817 DECATUR AVENUE NORTH NEW HOPE, MN 55428			
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01960	Continued From page 84 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960			
02320 SS=F	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of one unlicensed personnel (ULP-E) administered medications according to policy and accepted standards of practice. This had the potential to affect all residents receiving medications in 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: On August 6, 2024, the surveyor observed the following:	02320			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37091	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/07/2024
NAME OF PROVIDER OR SUPPLIER MILES VENTS INCORPORATED			STREET ADDRESS, CITY, STATE, ZIP CODE 5817 DECATUR AVENUE NORTH NEW HOPE, MN 55428		
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02320	Continued From page 85 - at 7:14 a.m., unlicensed personnel (ULP)-E removed R5's pill caddy from the cabinet, put medications into a pill cup and administered them to R5. ULP-E failed to check the medication caddy to the medications administration record prior to administering medications. - at 7:20 a.m., ULP-E removed R6's pill caddy from the cabinet, put medications into a pill cup and administered them to R6. ULP-E failed to check the medication caddy to the medications administration record prior to administering medications. - at 7:30 a.m., ULP-E removed R4's pill caddy from the cabinet, put medications into a pill cup and administered them to R4. ULP-E failed to check the medication caddy to the medications administration record prior to administering medications. - at 7:35 a.m., ULP-E removed R6 and R4's medication administration records (MARs) and documented administration. - at 8:00 a.m., ULP-E removed R2's pill caddy from the cabinet, put medications into a pill cup and administered them to R2. ULP-E failed to check the medication caddy to the medications administration record prior to administering medications. - at 9:30 a.m., ULP-E removed R3's pill caddy from the cabinet, put medications into a pill cup and administered them to R3. ULP-E failed to check the medication caddy to the MAR prior to administering medications. ULP-E removed R3's MAR and documented administration. On August 7, 2024, at 8:41 a.m. licensed assisted living director/registered nurse (LALD/RN)-A stated the staff were trained to check the MAR prior to administering medications and review the six rights of administration: right resident, right medication, right dose, right time, right route, and	02320			

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER MILES VENTS INCORPORATED		STREET ADDRESS, CITY, STATE, ZIP CODE 5817 DECATUR AVENUE NORTH NEW HOPE, MN 55428			
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02320	Continued From page 86 the right documentation. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320			



Minnesota Department of Health
Division of Environmental Health, FPLS
PO Box 64975
Saint Paul, 55164-0975
651-201-4500

Type: Full
Date: 08/06/24
Time: 09:33:06
Report: 1023241170

Food and Beverage Establishment Inspection Report

Page 1

Location:

Miles Vents Incorporated
5817 Decatur Avenue North
New Hope, MN55428
Hennepin County, 27

Establishment Info:

ID #: 0038788
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7632055880
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.

2-500 Responding to contamination events

2-501.11

**** Priority 2 ****

MN Rule 4626.0123 Provide employees with procedures to follow for cleanup of vomit or fecal matter in the establishment. The procedures must minimize the spread of contamination to food and surfaces within the facility, and minimize the exposure of employees and consumers to contamination.

NO PLAN AVAILABLE FOR REVIEW AND NO BLEACH AVAILABLE ON SITE. SENT SAMPLE PLAN WITH REPORT.

Comply By: 08/06/24

4-100 Equipment Construction Materials

4-101.17

MN Rule 4626.0490 Discontinue using wood and wood wicker as a food contact surface.

INSTRUCTED STAFF TO DISCARD WOODEN CUTTING BOARD.

Comply By: 08/06/24

Surface and Equipment Sanitizers

Hot Water: = at Degrees Fahrenheit
Location: ANSI 184 DISH MACHINE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Hold/MILK
Temperature: 41 Degrees Fahrenheit - Location: REACH IN COOLER
Violation Issued: No

Type: Full
Date: 08/06/24
Time: 09:33:06
Report: 1023241170
Miles Vents Incorporated

Food and Beverage Establishment Inspection Report

Page 2

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

THIS INSPECTION WAS CONDUCTED IN CONJUNCTION WITH MDH HEALTH REGULATORY DIVISION (HRD) SURVEY. INSPECTION CONDUCTED IN PRESENCE OF THE PERSON IN CHARGE.

THIS FACILITY DOES NOT HAVE ALL COMMERCIAL GRADE ANSI EQUIPMENT. ALL FOOD MUST BE SERVED THE SAME DAY IT IS PREPARED, AND LEFTOVERS CAN NEVER BE SAVED. FOOD SERVICE IS PROVIDED BY FACILITY STAFF.

FOOD SERVICE AREA FLOORS, WALLS, CEILINGS, COUNTERTOPS, AND FINISH MATERIALS MUST BE NON-ABSORBANT, SMOOTH, DURABLE, AND EASILY CLEANABLE. CEILINGS CANNOT HAVE POPCORN TEXTURE. CABINETS CANNOT HAVE HOLLOW BASES. EXPOSED WOOD IS NOT APPROVED FOR FOOD SERVICE AREAS. WOOD IS NOT AN APPROVED FOOD CONTACT SURFACE.

THESE TOPICS WERE DISCUSSED WITH THE PERSON IN CHARGE:

- EMPLOYEE ILLNESS EXCLUSION
- HAND WASHING PROCEDURE
- NO BARE HAND CONTACT WITH RTE FOOD
- VOMIT CLEAN UP PROCEDURE
- FULLY COOKING FOOD FOR HIGH RISK POPULATIONS
- ANSI 184 DISH WASHER

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 1023241170 of 08/06/24.

Certified Food Protection Manager: OSETOHAMEN AGENE

Certification Number: 107333 Expires: 08/14/27

Inspection report reviewed with person in charge and emailed.

Signed: _____

OSETOHAMEN AGENE
PERSON IN CHARGE

Signed: Gregory T Nelson

Gregory T. Nelson
Public Health Sanitarian
Freeman Building
651-201-4259
greg.nelson@state.mn.us