Electronically Delivered

February 11, 2025

Licensee
Teman Homes
910 Horn Drive
Minnetonka, MN 55305

RE: Project Number(s) SL34746017

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on December 19, 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 . . ."

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

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders 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.

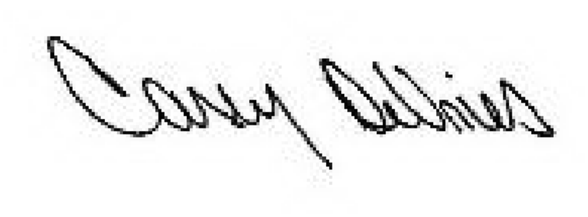
To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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,



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

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34746	A. BUILDING: _____ B. WING _____	12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TEMAN HOMES	910 HORN DRIVE MINNETONKA, MN 55305

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0 000	Initial Comments ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL34746017-0 On December 17, 2024, through December 19, 2024, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were five residents; five receiving services under the Assisted Living Facility with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food	0 480		

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0 480	Continued From page 1 must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean	0 480		

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0 480	Continued From page 2 and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated December 17, 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		

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0 650 SS=F	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee records included all required content for three of four employees (unlicensed personnel (ULP)-D, ULP-G, registered nurse (RN)-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	0 650		

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0 650	Continued From page 4 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 December 17, 2024, at 10:15 a.m., during the entrance conference, O-C stated they were aware of the required contents of employee records. ULP-D ULP-D had a hire date of June 27, 2024, and provided direct services to residents. On December 18, 2024, at 12:04 p.m., the surveyor observed ULP-D prepare and administer medications for R2. ULP-D's employee record included tuberculosis (TB) screening, training, and two chest X-Ray reports. Chest X-Ray reading, dated August 30, 2023, indicated the report was negative for active cardiopulmonary disease that included active TB. The Chest X-Ray report, dated September 6, 2024, indicated it was completed as a screening examination for pulmonary TB and included no abnormal findings. ULP-D's employee record did not include any historical positive TB testing results that would indicate appropriateness of chest X-Rays for monitoring. On December 18, 2024, at 1:50 p.m., owner (O)-C presented the surveyor with ULP-D's positive blood test result, dated June 13, 2024. O-C stated they had found ULP-D's positive TB test in their email. O-C stated they had received	0 650		

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0 650	Continued From page 5 the results back from the lab via email but had not printed and filed them into the employee record. ULP-G ULP-G had a hire date of October 18, 2024, and provided direct services to residents. ULP-G's employee record included TB screening, training, and a chest X-Ray report. The Chest X-Ray Reading, dated October 7, 2024, indicated the report was negative for active cardiopulmonary disease that included active TB. ULP-G's employee record did not include any historical positive TB testing results that would indicate appropriateness of chest X-Rays for monitoring. On December 18, 2024, at 1:50 p.m., O-C stated they knew they had TB blood test results for ULP-G, but they had not been able to locate them. O-C stated they would continue to look for the results. On December 18, 2024, at 2:32 p.m., O-C presented the surveyor with ULP-G's positive TB blood test result, dated October 1, 2024. O-C stated the test result was not in ULP-G's employee record but was with other papers that needed to be filed. RN-E RN-E had a hire date of May 30, 2024, and provided oversite to unlicensed personnel and direct services to residents. RN-E's record lacked verification of TB screening and testing completed prior to providing direct care to residents.	0 650		

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0 650	Continued From page 6 On December 18, 2024, at 1:50 p.m., O-C stated they knew they had TB screening and testing results for RN-E, but they had not been able to locate them. O-C stated they would continue to look for the results. On December 18, 2024, at 3:05 p.m., O-C presented the surveyor with RN-E's TB screening form, dated June 1, 2024. O-C stated they had found it with other papers that needed to be filed. On December 18, 2024, at 3:20 p.m., O-C presented the surveyor with RN-E's negative TB blood test results, dated June 18, 2024. O-C stated they found the test results mixed in with some other documentation. On December 18, 2024, at 3:20 p.m., O-C stated they would put documents in a pile with a plan to file them later but then get busy with other things and not get back to them. O-C stated they had a lot of documents in piles that needed to be filed. The licensee's Personnel Records policy dated March 25, 2024, indicated a personnel record would be started for each staff member upon hire and maintained throughout employment, then kept for at least three years after employment ended. The policy indicated that the personnel record would include the following information: - evidence of current professional licensure, registration or certification; - results of background studies; - records of annual training and infection control training; - documentation of orientation; - documentation of supervision; - performance reviews; - competency evaluations; and	0 650		

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0 650	Continued From page 7 - signed job description. In addition, the results of required health screening and medical examinations would be maintained in a separate, private file. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule.	0 680		

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0 680	Continued From page 8 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 failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's emergency disaster preparedness plan lacked evidence of the following required content: - policy and procedure (P/P) for ensuring food, water, medical supplies, and pharmaceutical supplies specific to facility residents; - P/P to address medical documentation to preserve resident information, protect confidentiality, and maintain availability of records; and - a written communication plan that included names and contact information of staff and residents' physicians. On December 18, 2024, at 1:06 p.m., owner (O)-C stated there was always food in the facility for at least seven days, but they had not calculated exactly how much food and water was needed for the five residents living in the facility.	0 680		

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0 680	Continued From page 9 There was not a specific allocation with a designated plan for an emergency situation. They did not have a menu that matched the supplies on-hand and no consideration for meal preparation for the on-hand supplies if power was lost. O-C stated they thought they had everything required on the communication plan. O-C reviewed the plan and stated they did not see resident physician contact information, other resident contacts such as family or guardians, or staff names and phone numbers. O-C stated they would update to make sure all of the information was in one place and easy for staff to access in an emergency. The licensee's Emergency Preparedness policy dated March 25, 2024, indicated licensee would have an identified plan in place to assure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupted services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law.	0 970		

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0 970	Continued From page 10 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 of a resident for three of three residents (R2, R3, R4). 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 was admitted to the licensee and began receiving assisted living services on May 2, 2024. R2's Assisted Living Contract was signed by R2's sister and clinical nurse supervisor (CNS)-A on April 29, 2024. R3 R3 was admitted to the licensee and began receiving assisted living services on November 22, 2024. R3's Assisted Living Contract was signed by R3's sister and CNS-A on November 25, 2024. R4 R4 was admitted to the licensee and began receiving assisted living services on July 1, 2024.	0 970		

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0 970	Continued From page 11 R4's Assisted Living Contract was signed by R4 and CNS-A on July 1, 2024. R2, R3, and R4's Assisted Living Contracts, included on page five, in a section titled Primary Services, number six of this section, titled Emergency Services/Staff Availability indicated licensee would not be liable for resident safety once the resident had departed the premises. Number seven of this section, on page five, titled Security/ Valuables/ Keys, indicated resident rooms had locks, and that if the resident chose not to lock their valuables, the resident was "responsible for the consequences". The contracts included, on page twelve, a section titled Miscellaneous Provisions. Part one of this section indicated licensee was not an "insurer of the resident's person or property" and that the resident was responsible to protect their own interests. The contract indicated that the resident "shall be responsible 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" the licensee or its employees or agents. The contracts included, on page thirteen, a section titled assignment. This section indicated licensee may assign the contract without consent of the resident, and in the event, licensee assigned the contract, the assignee would be "responsible for all liabilities and obligations, which arise or accrue from and after the date of assignment". The contract indicated the resident released the licensee from all liabilities or	0 970		

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0 970	Continued From page 12 obligations. On December 19, 2024, at 1:00 p.m., licensed assisted living director (LALD)-B stated they had worked on modifying the contract to remove any liability issues and they thought the current version was good. LALD-B stated they would continue to work on it. Licensee's Notifications policy, dated March 25, 2024, indicated that prior to providing housing or assisted living services, the assisted living contract would be presented and signed by the resident, the resident's designated representative, and/ or the resident's legal representative. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and	01060		

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01060	Continued From page 13 Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with required content for an emergency relocation for one of one resident (R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when	01060		

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01060	Continued From page 14 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: R4 R4 was admitted to the licensee and began receiving assisted living services on July 1, 2024. R4's diagnoses included vascular dementia, cardiomyopathy, coronary artery disease, type II Diabetes, traumatic brain injury, and anxiety. R4's Service Plan, dated September 8, 2024, indicated R4 received assistance with medication set up, medication administration, blood glucose monitoring, dressing, grooming, incontinence care, meals, and housekeeping. R4's record included a Hospital Discharge Summary, dated August 28, 2024, which indicated R4 was inpatient at a hospital beginning on August 26, 2024, and was discharged from the hospital on August 28, 2024. R4's Progress Note, dated August 30, 2024, indicated R4 returned to licensee on August 28, 2024, following a hospital admission. R4's record lacked a written notice delivered to the resident or designated representative that contained, at a minimum: - the reason for the relocation; - the name and contact information for the location to which the resident has been relocated and any new service provider; - contact information for the Office of Ombudsman for Long-Term Care (OOLTC) and the Office of Ombudsman for Mental Health and	01060		

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01060	Continued From page 15 Developmental Disabilities; - if known, the approximate date or range of dates within which the resident was expected to return to the facility, or a statement that a return date was not currently known; and - a statement that, if the facility refused to provide housing or services after a relocation, the resident had the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. On December 18, 2024, at 3:15 p.m., clinical nurse supervisor (CNS)-A stated they had not completed an emergency relocation form for R4 when they were hospitalized in August of 2024. CNS-A stated they were not aware of the requirements for emergency relocation. The licensee's Discharge and Transfer of Residents policy, dated March 25, 2024, indicated that in the event of an emergency relocation, the facility would provide written notice of emergency relocation to the resident, the resident's legal representative, the resident's designated representative, and the resident's case manager. The written notice would include the following information: - the reason for the relocation; - the name and contact information for the location to which the resident had been relocated to and any new service provider; - contact information for the OOLTC; - if known, the approximate date range within which the resident was expected to return to the facility or a statement that the date was not currently known; and - a statement that, if the facility refused to provide housing or services after a relocation, the resident had the right to appeal the decision and	01060		

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01060	Continued From page 16 contact information for the person to whom the resident should submit the appeal. In addition, if the resident had been relocated and not returned within four days, the licensee would notify the OOLTC. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
01620 SS=D	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 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.	01620		

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01620	Continued From page 17 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted a comprehensive assessment based on changes in the needs of the resident following an inpatient hospitalization for one of one resident (R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R4 was admitted to the licensee and began receiving assisted living services on July 1, 2024. R4's diagnoses included vascular dementia, cardiomyopathy, coronary artery disease, type II Diabetes, traumatic brain injury, and anxiety. R4's Service Plan, dated September 8, 2024, indicated R4 received assistance with medication set up, medication administration, blood glucose monitoring, dressing, grooming, incontinence care, meals, and housekeeping. R4's Hospital Discharge Summary, dated August 28, 2024, indicated R4 was seen in an emergency room on August 26, 2024, for chest pain and admitted to a hospital with a non-ST-segment elevation myocardial infarction (type of heart attack that occurred when an artery	01620		

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01620	Continued From page 18 was partially blocked, and blood flow to the heart was reduced). R4 was discharged back to the licensee with new medications and medical follow up required on August 28, 2024. R4's Nurse Note, dated August 30, 2024, completed by CNS-A indicated the note was a late entry for August 29, 2024, at 3:20 p.m., and that R4 had been hospitalized for two days and had returned to the facility on August 28, 2024. The note indicated CNS-A reviewed R4's medication changes from the hospital discharge information. CNS-A's note indicated R4's "vitals were stable", R4 "reported feeling better and denied any pain, shortness of breath, or tiredness. He also noted a good appetite and no issues with sleeping". R4's record included a comprehensive assessment completed prior to the hospitalization on August 22, 2024. The next comprehensive assessment included in the record was completed on September 15, 2024. The record lacked a comprehensive re-assessment completed following the change in R4's condition on August 28, 2024. On December 17, 2024, at 10:15 a.m., during the entrance conference, clinical nurse supervisor (CNS)-A stated they would complete a comprehensive nursing assessment using the uniform assessment tool in the resident's electronic medical record (EMR) for any change in condition. CNS-A stated a change in condition included when a resident had a fall, significant change in lab values, had an emergency room visit, or was hospitalized. On December 19, 2024, at 1:00 p.m., CNS-A stated they did not complete a comprehensive	01620		

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01620	Continued From page 19 assessment following R4's hospitalization in August 2024. CNS-A stated they thought the progress note they entered covered everything that was required for a resident returning from an inpatient hospitalization. The licensee's Assessment and Reassessment policy dated March 25, 2024, indicated the RN would complete an initial assessment for each resident on or before the date the resident moved into the facility, reassessment would occur no more than fourteen days after initiation of services, and ongoing reassessments would not exceed ninety days from the last date of assessment. Ongoing resident monitoring would be conducted as needed based on changes in the needs of the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01640 SS=F	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman	01640		

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01640	Continued From page 20 for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. 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 a signature or other authentication by the licensee and resident or resident's designated representative to document agreement on the services to be provided for two of two residents (R2, R3) and failed to ensure services were provided as required in the current service plan for two of two residents (R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an widespread scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On December 17, 2024, at 10:15 a.m., during the entrance conference, CNS-A stated they were responsible for developing and updating the resident's service plans. AUTHENTICATION	01640		

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01640	Continued From page 21 R2 R2 was admitted to the licensee and began receiving assisted living services on May 2, 2024. R2's diagnoses included vascular dementia, type II Diabetes, and hypertension. R2's Service Plan, dated as effective September 5, 2024, indicated R2 received assistance with medication administration, dressing, grooming, bathing, toileting, behavior management, meals, and housekeeping. On December 18, 2024, at 12:04 p.m., the surveyor observed unlicensed personnel (ULP)-D prepare and administer medications for R2 On December 18, 2024, at 11:51 a.m., clinical nurse supervisor (CNS)-A stated they had updated R2's service plan and requested a signature from R2's guardian. CNS-A stated the guardian took the document home with them to review and had not brought it back yet. On December 18, 2024, at 12:25 p.m., CNS-A stated they had some communication by text message with R2's guardian about getting the signed service plan back to the facility, but they were unable to view the text history. CNS-A stated they must have deleted the text messages. R2's record lacked documentation of the updated service plan and communication with R2's guardian related to the updated service plan and the need for signature. On December 18, 2024, at 2:48 p.m., CNS-A returned to the facility after taking a resident to a medical appointment. CNS-A stated they had	01640		

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01640	Continued From page 22 stopped at R2's guardian's location and picked up the signed service plan. CNS-A provided the surveyor with R2's Service Plan, dated as effective September 5, 2024. The document was signed and dated by CNS-A on September 7, 2024, and by R2's guardian on September 12, 2024. R3 R3 was admitted to the licensee and began receiving assisted living services on November 22, 2024. R3's diagnoses included asthma, anoxic brain injury, coronary artery disease, history of cardiac arrest, hypertension, anxiety, and depression. R3's Service Plan, dated December 6, 2024, indicated R3 received assistance with medication administration, dressing, grooming, toileting, blood pressure monitoring, meals, and housekeeping. The service plan was signed by R3's family member and was dated December 7, 2024. The space designated for signature of licensee representative was left blank. On December 19, 2024, at 1:00 p.m., CNS-A stated they did not realize they had not signed R3's service plan before it was filed into the record. CNS-A stated they should have signed it. On December 19, 2024, at 1:00 p.m., CNS-A stated their procedure for updating the service plan was to notify family of changes by phone, provide staff education, update the electronic medical record (EMR) to reflect the changes that generated the new service plan, print the new service plan, then obtain resident and family signatures. CNS-A stated how signatures were obtained depended on the preferences of the	01640		

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01640	Continued From page 23 family as some liked to sign in person at the facility and some preferred to be sent documents for signature via email. CNS-A stated when resident's family members had taken documents home to review them before signing, they had not documented it in the resident's record but indicated they planned to going forward. SERVICE REQUIRED BY THE SERVICE PLAN R2 R2's Service Plan, dated September 5, 2024, indicated R2 received assistance from a licensed practical nurse (LPN) with medication setup one day each week. On December 28, 2024, at 12:04 p.m., the surveyor observed ULP-D prepare and administer medications for R2. ULP-D reviewed R2's MAR on the EMR, then obtained the scheduled medications from the medication cart. ULP-D compared the labels with the MAR when they set up divalproex sodium 125 mg one capsule and Tylenol 650 mg one tablet. The divalproex was on a bubble pack card with each individual dose in its own bubble prepared by the pharmacy, ULP-D punched one capsule form the bubble pack into a plastic medication cup. The Tylenol was in a bottle that ULP-D removed one tablet from and placed it into the plastic medication cup. ULP-D administered the medications to R2 and documented in the EMR. R3 R3's Service Plan, dated December 6, 2024, indicated R3 received assistance from a LPN with medication setup one day each week. On December 17, 2024, at 5:00 p.m., the surveyor observed the facility medication cart with	01640		

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01640	Continued From page 24 CNS-A and owner (O)-C. The medication cart contained medications for all of the facility residents. Medications for R2 and R3 were in bubble packs and bottles. The surveyor did not observe any prepared medication boxes designated for R2 or R3 in the medication cart. On December 19, 2024, at 1:00 p.m., CNS-A stated the weekly medication set up on the service plans was a mistake. CNS-A stated they did not set up medications for R2 or R3. The licensee's Service Plan policy dated March 25, 2024, indicated an individualized service plan would be implemented for all residents. The service plan would be developed based on the assessed needs of the resident and revised when needed based on resident review or reassessment. The initial service plan and any revisions would be signed by the licensee and the resident or the resident's representative. The signatures indicated agreement with the services to be provided. The licensee would implement and provide all the services required by the resident's current service plan. The service plan and all revisions would be entered into the resident's record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription	01890		

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01890	Continued From page 25 label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure time-sensitive medications were labeled with the date opened for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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: R2 was admitted to the licensee and began receiving assisted living services on May 2, 2024. R2's diagnoses included vascular dementia, type II Diabetes, and hypertension. R2's Service Plan, dated September 5, 2024, indicated R2 received assistance with medication administration, dressing, grooming, bathing, toileting, behavior management, meals, and housekeeping. R2's Medication Administration Record (MAR), dated December 2024, indicated R2 received fluticasone salmeterol 500 micrograms (mcg)/ 50 mcg per actuation one puff inhaled two times daily.	01890		

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01890	Continued From page 26 On December 18, 2024, at 12:04 p.m., the surveyor observed unlicensed personnel (ULP)-D prepare and administer medications for R2. On December 18, 2024, at 12:10 p.m., the surveyor observed the following medication that belonged to R2 in the medication cart: - fluticasone propionate salmeterol diskus inhalation powder 500 mcg/ 50 mcg. The inhaler device was in its original manufacturer box. The counter on the device indicated the number 58, which meant the device was open and in use, with two doses having been administered from the device. The box and the device lacked documentation of the date the device was opened. On December 18, 2024, at 12:10 p.m., ULP-D stated they did not put the date they opened the medication on the fluticasone propionate salmeterol diskus inhalation powder device. ULP-D stated they looked at the counter to see how much medication was left when administering it to R2. On December 19, 2024, at 1:00 p.m., clinical nurse supervisor (CNS)-A stated they had not required staff to put a date on R2's fluticasone propionate salmeterol diskus inhalation powder device when they opened it because the counter on the device told them how much medication was left in it. CNS-A stated there was no way to know when the device was opened based on how much medication was left in the device. Licensed assisted living director (LALD)-B stated staff should start putting the date on all medications when they were opened because it was best practice to do so.	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34746	A. BUILDING: _____ B. WING _____	12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TEMAN HOMES	910 HORN DRIVE MINNETONKA, MN 55305

(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
01890	Continued From page 27 The manufacturer's instructions for fluticasone Propionate/Salmeterol diskus inhalation powder device indicated the device should be stored in the unopened foil pouch and only opened when ready for use. In addition, the device should be thrown in the trash one month after opening the foil pouch or when the counter read zero, whichever came first. The licensee's Storage/ Control of Medications policy dated March 25, 2024, indicated medications stored by licensee would be maintained according to the manufacturer's instructions. In addition, the licensed nurse was responsible for ensuring time sensitive medications were dated when opened. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		

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

Type: Full
Date: *12/17/24*
Time: 13:00:00
Report: 8041241240

Food and Beverage Establishment Inspection Report

Location:
Teman Homes
910 Horn Drive
Minnetonka, MN55305
Hennepin County, 27

Establishment Info:
ID #: 0037841
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 9125786695
ID #:

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

The following orders were issued during this inspection.

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

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

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

PACKAGE OF RAW BACON STORED ABOVE READY-TO-EAT FOODS IN THE KITCHEN COOLER. CORRECTED ON SITE. BACON WAS MOVED TO BOTTOM SHELF IN COOLER.

Comply By: 12/17/24

3-500B Microbial Control: hot and cold holding

3-501.16A2 ***** Priority 1 *****

MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.

TCS FOODS IN THE COMMERCIAL KITCHEN COOLER MEASURED 44-45 DEG. F. ADJUST/REPAIR TO MAINTAIN FOOD AT 41 F OR BELOW.

Comply By: 12/17/24

Surface and Equipment Sanitizers

Utensil Surface Temp.: = at 163 Degrees Fahrenheit
Location: dish machine
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 45 Degrees Fahrenheit - Location: kitchen cooler: deli ham
Violation Issued: Yes

Type: Full
Date: *12/17/24*
Time: 13:00:00
Report: 8041241240
Teman Homes

Food and Beverage Establishment Inspection Report

Process/Item: Cold Holding
Temperature: 45 Degrees Fahrenheit - Location: kitchen cooler: milk
Violation Issued: Yes

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

Inspection was completed with Femi and Pheyi Ojo. Peggy Anderson was the lead Health Regulation Division Nurse Evaluator. Facility had five residents on site at time of inspection.

This establishment has a residential kitchen with mostly commercial equipment and finishes. Food is prepared for same day service only.

Establishment has a dishwasher that has a sani rinse/high temp cycle and achieved a temp at least 160F for sanitizing dishes. Kitchen a separate handwashing sink. The refrigerator in the basement is for staff food only. There is also a freezer in the basement that is used by establishment.

Discussed the following:
- Employee illness policy and logging requirements
- Reportable diseases
- Handwashing
- Glove-use and bare hand contact
- Food storage and preventing cross contamination
- Date marking
- Restrictions concerning serving a highly susceptible population
- Vomit clean up process

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 8041241240 of 12/17/24.

Certified Food Protection Manager: Mofeyisola O. Ojo

Certification Number: fm119704 Expires: 10/30/26

Inspection report reviewed with person in charge and emailed.

Signed: _____
Femi Ojo

Signed: Sarah Conboy
Sarah Conboy
Public Health San. Supervisor
651-201-3984
sarah.conboy@state.mn.us