DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

August 16, 2023

Licensee
Family Tree Care Homes LLC
3233 Richmond Avenue
Shoreview, MN 55126

RE: Project Number(s) SL38206015

Dear Licensee:

On August 14, 2023, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the June 7, 2023, 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,

Jessie Chenze, Supervisor
State Evaluation Team
Email: jessie.chenze@state.mn.us
Telephone: 218-332-5175 Fax: 651-281-9796

JMD

Electronically Delivered

June 26, 2023

Licensee
Family Tree Care Homes, LLC
3233 Richmond Avenue
Shoreview, MN 55126

RE: Project Number(s) SL38206015

Dear Licensee:

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

The Minnesota Department of Health completed an initial survey on June 7, 2023, for the purpose assessing compliance with state licensing statutes. At the time of the survey, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G.

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

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

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

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

Please email reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

Please address your cover letter for reconsideration requests to:

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

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

If you have any questions, please contact me.

Sincerely,

Jessica Chenze, Supervisor
State Evaluation Team
Email: jessica.chenze@state.mn.us
Telephone: 218-332-5175 Fax: 651-281-9796

PMB

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	38206		06/07/2023

NAME OF PROVIDER OR SUPPLIER

FAMILY TREE CARE HOMES LLC

STREET ADDRESS, CITY, STATE, ZIP CODE

3233 RICHMOND AVENUE
SHOREVIEW, MN 55126

(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: SL38206015 On June 5, 2023, through June 7, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were four active residents; three receiving services under the Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the	0 480		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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0 480	Continued From page 1 following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated June 5, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 510 SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in	0 510		

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0 510	Continued From page 2 assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure infection control standards were followed for one of two employees (unlicensed personnel/ULP-C) during personal cares for 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) 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 June 6, 2023, at 9:41 a.m., the surveyor observed ULP-C and clinical nurse supervisor (CNS)-B enter R2's room. ULP-C and CNS-B used hand sanitizer and donned a pair of gloves. ULP-C and CNS-B positioned R2 on to her left side and removed R2's brief. R2's brief was observed to be wet with a smear of incontinent bowel. ULP-C using gloved hands and several disposable wipes cleaned R2's bottom and provided peri-care. The surveyor did not observe ULP-C to remove her gloves and perform hand hygiene following incontinence care. With the same gloved hands ULP-C placed a quarter-sized amount of Calmoseptine ointment (barrier cream) onto her gloved hand and applied the barrier cream to R2's bottom. ULP-C and CNS-B proceeded to apply a new brief and	0 510		

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0 510	Continued From page 3 removed their gloves. ULP-C and CNS-B repositioned R2 in bed and prior to exiting R2's room used hand sanitizer. On June 6, 2023, at 9:50 a.m., ULP-C stated she had not changed her gloves and performed hand hygiene after she had provided incontinence care and prior to applying the barrier cream to R2's bottom. ULP-C stated she was aware hand hygiene should have been done between these tasks but had been "nervous". On June 6, 2023, at 10:12 a.m., CNS-B stated staff were to change gloves and perform hand hygiene after providing incontinence care, any time their gloves became soiled, prior to providing barrier cream, and after removal of gloves. The Centers for Disease Control (CDC) Hand Hygiene in Health Care Settings Hand Hygiene Guidance dated January 30, 2020, directed healthcare personnel to wash their hands or use hand sanitizer immediately before performing aseptic task, before moving from work on a soiled body site to a clean body site, after contact with blood, body fluids, or contaminated surfaces, and immediately after glove removal. The licensee's Procedure for Using Gloves dated February 1, 2023, noted gloves are to be worn whenever there may be direct contact between the caregiver's hands and blood, body fluids, secretions, feces, or a contaminated item. If gloves become torn or heavily soiled and additional tasks must be performed for the client, then change the gloves washing hands before putting on new gloves before starting the next task. No further information was provided.	0 510		

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0 510	Continued From page 4 TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
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. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop and post a written emergency preparedness plan (EPP) with all the required content. This had the potential to	0 680		

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0 680	Continued From page 5 affect all residents, staff, and visitors of 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 June 5, 2023, at 2:44 p.m., the surveyor completed the facility tour with licensed assisted living director (LALD)-A. The surveyor did not observe signage posted or information regarding the licensee's EPP in the common areas of the facility. LALD-A stated the EPP was in a binder on a shelf in the locked medication closet. LALD-A confirmed the licensee's EPP was not prominently posted. The licensee's undated EPP provided to the surveyor included an undated Hazard Vulnerability Assessment (HVA) for each bedroom at the facility. The only potential hazard identified included oxygen concentrators in Bedroom #1 and Bedroom #2. The EPP binder included generic instructions for staff to follow in case of a fire, severe weather, power outages, and an evacuation. The licensee's EPP provided did not include the following: - a completed HVA - policies and procedures to address natural and man-made disasters - a quarterly review of the missing resident policy - a description of the facilities approach to meeting the health/safety/security needs of the	0 680		

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0 680	Continued From page 6 staff and residents; - process for EP cooperation with state and local EP officials/organizations; - a description of the population served by the licensee; - development of policies/procedures to address: - procedure for tracking staff and residents; - subsistence needs for staff and residents during an emergency to include (food, water, medical supplies, pharmacy supplies, sewer and waste disposal, emergency lighting, fire detection, extinguishing and alarm systems; - evacuation plan which included staff responsibilities during an evacuation and transporting services for residents being evacuated; - shelter in place; - a medical record documentation system to preserve resident information, security, and availability; - emergency staffing strategies to include volunteers; and - the facilities role in providing care and treatment at alternative sites under a 1135 waiver; - a communication plan that included: - names and contact information for staff, entities providing services under arrangement, resident physicians, other facilities, volunteers; - contact information for federal, state, tribal, local EP staff, ombudsman, state licensing and certification agencies; - primary and alternative means for communicating with facility staff, federal, state, regional and local emergency management agencies; - a method of sharing information and medical documentation for residents; - a means to provide information regarding the facility's needs, and its ability to provide assistance to include information about their	0 680		

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0 680	Continued From page 7 occupancy; and - a method of sharing information from the EPP with residents and their families. - an EP training and testing program On June 6, 2023, at 2:29 p.m., LALD-A stated he was aware the facility's EPP was not fully developed. The licensee's undated Emergency and Disaster Preparedness policy noted the emergency disaster plan would be posted prominently. A HVA would be completed and a EPP would be developed. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
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:	0 790		

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0 790	Continued From page 8 Based on observation and interview, the licensee failed to maintain the portable fire extinguishers. This deficient condition had the ability to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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). Findings include: On June 6, 2023, between 11:30 a.m. and 12:10 p.m., survey staff toured the facility with the licensed assisted living director (LALD)-A. During the facility tour, survey staff observed two portable fire extinguishers with service tags dated October 2021. Fire extinguishers need to be maintained annually by certified personnel so that they can be used reliably and effectively in an emergency. This deficient condition was verified by the LALD-A accompanying on the facility tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		
0 800 SS=E	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the	0 800		

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0 800	Continued From page 9 health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). Findings include: On June 6, 2023, between 11:30 a.m. and 12:10 p.m., survey staff toured the facility with the licensed assisted living director (LALD)-A. During the facility tour, survey staff observed that the faucet was leaking around the base for the vanity sink in the main floor common-use bathroom. This deficient condition was verified by the LALD-A accompanying on the facility tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		

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0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at 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 record review and interview, the	0 810		

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0 810	Continued From page 11 licensee failed to develop fire safety and evacuation plans with the required elements, failed to provide resident training, and failed to meet the required evacuation drill frequency for employees. These deficient conditions had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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). Findings include: On June 6, 2023, at approximately 12:10 p.m., records were provided for review. Records were reviewed by survey staff on June 6, 2023, between 12:10 p.m. and 12:45 p.m. 1. Record review of the available documentation indicated that the fire safety and evacuation plans had not been developed with complete employee actions on how to move or evacuate residents in the event of a fire or similar emergency from this facility location. The plans indicated to use the RACE acronym and included vague instructions for employees. The plans did not provide complete actions for employees to take in the event of a fire or similar emergency or specific fire protection procedures necessary for residents. 2. Record review indicated that annual training for residents capable of assisting in their own evacuation on the proper actions to take in the event of a fire to include movement, evacuation, or relocation had not been documented.	0 810		

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	38206		06/07/2023

NAME OF PROVIDER OR SUPPLIER

FAMILY TREE CARE HOMES LLC

STREET ADDRESS, CITY, STATE, ZIP CODE

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0 810	Continued From page 12 3. Record review of the available documentation indicated that employee evacuation drills had not been documented to support that the evacuation drill frequency requirement of twice per year per shift with at least one evacuation drill every other month had been met. Evacuation drills had been completed in February, April, and June 2023. The time or shift had not been recorded. No additional evacuation drill records were provided. On June 6, 2023, at approximately 12:50 p.m., the licensed assisted living director (LALD)-A verified these deficient conditions. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 900 SS=D	144G.50 Subdivision 1 Contract required (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.	0 900		

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0 900	Continued From page 13 (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 observation and interview, the licensee failed to develop and execute a written contract, with the required content for one of one renter (R4) who was residing in the basement apartment of 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, 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 June 5, 2023, at 2:17 p.m., during the tour of the facility with clinical nurse supervisor (CNS)-B the surveyor observed an elderly gentleman exiting a room in the basement of the facility. On June 5, 2023, at 2:31 p.m., CNS-B stated her father (R4) lived in a room in the basement of the facility. CNS-B stated R4 did not received any	0 900		

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0 900	Continued From page 14 services but did reside at the facility. CNS-B stated R4 did not have an assisted living contract. CNS-B stated she was unaware of the regulation that an assisted living may not provide housing to any individual unless they had executed a contract and developed an individualized abuse prevention plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	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 facility's liability for health, safety, or personal property of a resident. This had the potential to affect all residents. 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	0 970		

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0 970	Continued From page 15 or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: The assisted living contract provided included a clause that indicated the resident would waive the facility's liability for health, safety, or personal property of the resident. Section 29. Liability, indicated the landlord (licensee) was not liable to the tenant (resident) for any injury, death, or property damage occurring in the bedroom unit or on landlord's premises unless such injury, death or property damage occurs as the result of an equipment malfunction or hazardous conditions within the building not caused by the tenant. Landlord may be liable to the tenant for its own negligent acts or those of its employees or agents. Unless caused by one of the aforementioned excepted reasons, tenant agrees to hold landlord harmless from any and all claims for injuries, property damage or any other loss resulting from an accident or other occurrence in the bedroom unit or on landlord's premises. On June 7, 2023, at 9:48 a.m., licensed assisted living director (LALD)-A stated he was aware this section of the contract needed to be revised. LALD-A stated the assisted living contract provided was the same contract used for all residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 970		

Minnesota Department of Health

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01290	Continued From page 16	01290		
01290 SS=F	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure a background study was affiliated with the assisted living license for two of two employees (clinical nurse supervisor/CNS-B, unlicensed personnel/ULP-C). 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: CNS-B	01290		

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01290	Continued From page 17 CNS-B was hired on June 13, 2022, to provide direct care services to the facility's residents and oversee the staff at the assisted living. CNS-B's record lacked documentation of a background study affiliated with the facility's license. ULP-C ULP-C was hired on September 26, 2022, to provide direct care services to the facility's residents. On June 6, 2023, at 9:20 a.m., the surveyor observed ULP-C conduct R1's blood glucose monitoring check and administer R1's scheduled insulin dose. At 9:54 a.m., the surveyor observed ULP-C administer R3's scheduled morning medications. ULP-C's record lacked documentation of a background study affiliated with the facility's license. On June 7, 2023, at 10:28 a.m., licensed assisted living director (LALD)-A stated he was aware ULP-C and CNS-B's background study was not affiliated with the facility's license. LALD-A stated they both had cleared background studies affiliated with the other assisted living with dementia care facility they owned. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01690 SS=F	144G.71 Subdivision 1 Medication management services	01690		

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01690	Continued From page 18 (a) This section applies only to assisted living facilities that provide medication management services. (b) An assisted living facility that provides medication management services must develop, implement, and maintain current written medication management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse, licensed health professional, or pharmacist consistent with current practice standards and guidelines. (c) The written policies and procedures must address requesting and receiving prescriptions for medications; preparing and giving medications; verifying that prescription drugs are administered as prescribed; documenting medication management activities; controlling and storing medications; monitoring and evaluating medication use; resolving medication errors; communicating with the prescriber, pharmacist, and resident and legal and designated representatives; disposing of unused medications; and educating residents and legal and designated representatives about medications. When controlled substances are being managed, the policies and procedures must also identify how the provider will ensure security and accountability for the overall management, control, and disposition of those substances in compliance with state and federal regulations and with subdivision 23. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the security and accountability of controlled substances were maintained for one of one resident (R2).	01690		

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01690	Continued From page 19 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On June 5, 2023, at 1:30 p.m., during the entrance conference clinical nurse supervisor (CNS)-B stated all narcotic medication was double locked and counted daily. On June 5, 2023, at 2:17 p.m., the surveyor toured the facility with CNS-B, including a review of the locked narcotic box in the locked basement of the facility. The narcotic box contained the following medications which CNS-B visualized the medication bottles and stated the below noted amounts of each bottle: - one unopened bottle of Methadose 10 milligrams/milliliter (mg/ml) (narcotic pain medication) containing 60 ml for R2 - one opened bottle of Methadose 10 mg/ml containing 20 ml for R2 - one unopened bottle of oxycodone hydrochloride 100 mg/5 ml (narcotic pain medication) containing 30 ml for R2 - one opened bottle of oxycodone hydrochloride 100 mg/5ml containing 19 ml for R2 On June 5, 2023, at 2:24 p.m., the surveyor asked CNS-B for the narcotic logs for the above noted medications. CNS-B stated she only documents on a piece of paper when she filled the syringes (piece of paper provided was titled	01690		

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01690	Continued From page 20 "MEMO" and in the "FROM" section it was written "Methadone [nickname of R2]" with weekly dates from "4/22 - 5/31" listed. Following each date was the notation "filled 18 [check mark]" and CNS-B's initials.) CNS-B stated the licensee did not have a system in place to routinely count narcotics. CNS-B stated, "I knew this would be a problem". The licensee's Controlled Substances/Schedule II Drugs policy dated August 1, 2021, noted assisted living staff, including a licensed nurse whenever possible, will use a preferred practice of counting controlled drugs at the end of each shift if medications were stored securely outside of the resident's room. The staff person coming on duty and the staff person going off duty will count the controlled medications together and will document and report any discrepancies immediately to the registered nurse. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01690		
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	01700		

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01700	Continued From page 21 an identification and review of all medications the resident is known to be taking. The review and 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 a medication management assessment was completed by the registered nurse/RN to determine what medication management services would be provided and included identification and review in all required areas for one of one resident (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) 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: During the entrance conference on June 5, 2023,	01700		

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01700	Continued From page 22 at 1:30 p.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to residents at the facility. R2's diagnoses included hypertension, chronic kidney disease and heart failure (condition in which the heart's function as a pump is inadequate to meet the body's needs). R2's service plan and Individualized Medication Management Plan dated November 17, 2022, indicated R2 received medication management services to include medication setup and medication administration. R2's prescriber orders dated March 28, 2023, included one scheduled narcotic pain medication, one as needed narcotic pain medication, one laxative, one antidepressant, one as needed barrier cream, and one antipsychotic. On June 6, 2023, at 8:09 a.m., the surveyor observed licensed assisted living director (LALD)-A administer R2's scheduled morning medications. R2's record lacked evidence the RN conducted a face-to-face assessment with the resident and/or their representative to include a review of all medications the resident was known to be taking to include indications for use, side effects, contraindications, allergic or adverse reactions and actions to address these issues. On June 7, 2023, at 10:20 a.m., CNS-B stated R2 had not had a medication management services assessment completed to include all the above noted content. CNS-B stated this would be the same for all residents at the facility who received medication management services.	01700		

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01700	Continued From page 23 The licensee's undated Medication Management Services policy noted based on the nursing assessment, the RN would develop an individualized medication management plan for each resident receiving any type of medication management services, consistent with current practice standards and guidelines. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01700		
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed	01730		

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01730	Continued From page 24 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 maintain a current individualized medication management plan for each resident to include all required content for one of one resident (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) 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: During the entrance conference on June 5, 2023, at 1:30 p.m., the clinical nurse supervisor	01730		

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01730	Continued From page 25 (CNS)-B stated the licensee provided medication management services to residents at the facility. R2's diagnoses included hypertension, chronic kidney disease and heart failure (condition in which the heart's function as a pump is inadequate to meet the body's needs). R2's service plan dated November 17, 2022, indicated R2 received medication management services to include medication setup and medication administration. R2's prescriber orders dated March 28, 2023, included one scheduled narcotic pain medication, one as needed narcotic pain medication, one laxative, one antidepressant, one as needed barrier cream, and one antipsychotic. On June 6, 2023, at 8:09 a.m., the surveyor observed licensed assisted living director (LALD)-A administer R2's scheduled morning medications. R2's Individualized Medication Management Plan dated November 17, 2022, did not include documentation medication reconciliation had been completed. On June 7, 2023, at 10:25 a.m., CNS-B stated R2's medication management plan did not include medication reconciliation. CNS-B stated this would be the same for all residents at the facility who received medication management services. The licensee's undated Development of the Individualized Medication Management Plan and Individualized Medication Record policy noted based on the comprehensive nursing	01730		

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	38206		06/07/2023

NAME OF PROVIDER OR SUPPLIER

FAMILY TREE CARE HOMES LLC

STREET ADDRESS, CITY, STATE, ZIP CODE

3233 RICHMOND AVENUE
SHOREVIEW, MN 55126

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01730	Continued From page 26 assessment, the RN would develop an individualized medication management plan for each resident that needs or requests medication management services. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01760 SS=E	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 the steps of the medication administration process was followed for one of two employees (unlicensed personnel/ULP-C) observed administering medications for two of three residents (R2, R3); and failed to ensure medications were administered as ordered for one of three residents (R2) who received medication	01760		

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01760	Continued From page 27 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: MEDICATION ADMINISTRATION PROCESS - NOT DOCUMENTING MEDICATIONS AS GIVEN R2's diagnoses included hypertension, chronic kidney disease and heart failure (condition in which the heart's function as a pump is inadequate to meet the body's needs). R2's service plan and Individualized Medication Management Plan dated November 17, 2022, indicated R2 received medication management services to include medication administration. R2's prescriber orders dated March 28, 2023, included an order for Calmoseptine ointment (barrier cream) to be applied to affected areas each time if needed for diaper rash or irritation. On June 6, 2023, at 9:41 a.m., the surveyor observed ULP-C and clinical nurse supervisor (CNS)-B enter R2's room. ULP-C and CNS-B used hand sanitizer and donned a pair of gloves. ULP-C and CNS-B positioned R2 on to her left side and removed R2's brief. R2's brief was observed to be wet with a smear of incontinent bowel. ULP-C using gloved hands and several disposable wipes cleaned R2's bottom and	01760		

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01760	Continued From page 28 provided peri-care. With the same gloved hands ULP-C placed a quarter-sized amount of Calmoseptine ointment (barrier cream) onto her gloved hand and applied the barrier cream to R2's bottom. R2's PRN (as needed) medication administration record (MAR) for June 2023, did not include Calmoseptine ointment administration. On June 7, 2023, at 10:10 a.m., clinical nurse supervisor (CNS)-B stated R2's PRN medication record did not include a place for staff to document when Calmoseptine ointment was applied as ordered. MEDICATION ADMINISTRATION PROCESS - SIGNING OFF MEDICATIONS PRIOR TO ADMINISTRATION Medications for R3 were documented by ULP-C as being administered prior to the medication being administered. On June 6, 2023, at 9:28 a.m., the surveyor observed ULP-C to administer R3's scheduled morning medications. The following was observed: - ULP-C removed from the locked medication closet R3's scheduled Senna 8.6-50 milligrams (mg) two tablets - ULP-C placed the medication into a medication cup - ULP-C checked the MAR and initialed R3's MAR by the medication she had checked indicating the medication had been administered - ULP-C brought the medication to R3 who was seated at the kitchen counter/bar - R3 took the medication with a sip of water	01760		

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01760	Continued From page 29 On June 6, 2023, at 9:54 a.m., ULP-C stated she had signed off R3's Senna prior to R3 taking the medication. ULP-C stated she knew she shouldn't sign a medication off until after the resident had taken the medication. On June 7, 2023, at 10:10 a.m., CNS-B stated she had instructed the staff when administering medications to sign off the medications after the resident had taken the medication. The licensee's Documentation of Medication, Treatment and Therapy Management Services policy dated December 10, 2022, noted staff will appropriately document all medications, treatments and therapy management services provided to residents including documentation of PRN medications. Staff will document each task immediately after that task has been performed. MEDICATION ERROR R2's diagnoses, service plan and Individualized Medication Management Plan as noted above. R2's prescriber orders dated March 28, 2023, included an order for Senokot S 8.6-50 mg take two (2) tablets by mouth once daily. R2's June 1, 2023, through June 5, 2023, MAR indicated Senna-S 8.6-50 mg one (1) tablet was scheduled and had been administered once daily at 8:00 p.m. On June 7, 2023, at 10:07 a.m., CNS-B reviewed R2's most current provider orders (dated March 28, 2023) and stated the orders directed for two tablets of Senna-S to be administered daily and only one tablet had been administered daily. CNS-B stated she thought she had an older order for only one tablet to be administered daily, but	01760		

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01760	Continued From page 30 maybe when the provider signed the most current orders, he didn't review the older orders closely. The licensee's undated Medication Management Services policy noted the RN or licensed practical nurse (LPN) would review each resident's medication record at appropriate times based on the resident's needs and the resident's medication management services to verify that staff are administering the medications as prescribed and are documenting the administration appropriately. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01770 SS=D	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure documentation of medication setup included all the required content for one of one resident (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	01770		

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01770	Continued From page 31 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: During the entrance conference on June 5, 2023, at 1:30 p.m., the clinical nurse supervisor (CNS)-B stated the licensee provided medication management services which included medication setup. R2's diagnoses included hypertension, chronic kidney disease and heart failure (condition in which the heart's function as a pump is inadequate to meet the body's needs). R2's service plan and Individualized Medication Management Plan dated November 17, 2022, indicated R2 received medication management services to include medication setup. R2's prescriber orders dated March 28, 2023, included an order for the following: - Methadone concentrate 5 milligrams (0.5 milliliters/ml) orally three times daily; and - Haldol 1.5 mg (0.75 ml) orally three times daily and every one hour as needed On June 5, 2023, at 1:57 p.m., the surveyor reviewed the locked medication closet with CNS-B. Observed in the locked narcotic box was the following: - one clear plastic baggie with two (2) unlabeled preset 0.5 ml syringes with the following information handwritten with black marker on the outside of the plastic baggie, "Methadone 0.5" - one clear plastic baggie with two (2) unlabeled preset 0.75 ml syringes with the following	01770		

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01770	Continued From page 32 information handwritten with black marker on the outside of the plastic baggie, "Haldol 0.75" CNS-B stated she had preset the above noted syringes for R2. On June 5, 2023, at 2:24 p.m., CNS-B stated she documented on a piece of paper when she filled the syringes (piece of paper provided was titled "MEMO" and in the "FROM" section it was written "Methadone [nickname of R2]" with weekly dates from "4/22 - 5/31" listed. Following each date was the notation "filled 18 [check mark]" and CNS-B's initials.) R2's record lacked documentation for medication setup at the time of setup to include the dates of medication setup, name of the medication, quantity of dose, times to be administered, route of administration and name of person completing medication setup for R2's Methadone and Haldol noted above. On June 7, 2023, at 9:56 a.m., CNS-B stated medication setup for R2's liquid Methadone and Haldol had not been documented as required. The licensee's undated Medication Management Services policy noted when setting up medication for later administration the registered nurse or licensed practical nurse will verify that the dose and quantity of medications delivered was consistent with the prescription; review prescribed medications to identify any contraindications or other concerns; identify whether refills are needed; and verify that medications for the previous period were administrated as prescribed. No further information was provided.	01770		

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01770	Continued From page 33 TIME PERIOD FOR CORRECTION: Seven (7) days	01770		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of one medication refrigerator maintained an acceptable temperature and medications was stored according to manufacturer's recommended temperature. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On June 5, 2023, at 2:14 p.m., the surveyor toured the facility with clinical nurse supervisor (CNS)-B, including a review of the medication refrigerator located in the locked basement of the facility. CNS-B stated there was not a thermometer in the medication refrigerator. CNS-B stated the temperature of the medication refrigerator was not being monitored.	01880		

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01880	Continued From page 34 The medication refrigerator contained the following medications: - four unopened Lantus 100 units/milliliter (ml) insulin pens for R1 - ten unopened Novolog 100 units/ml insulin pens for R1 The manufacturer's instructions for Lantus insulin pens dated May 2019, indicated unopened pens should be stored in the refrigerator between 36 to 46 degrees Fahrenheit (F). Do not allow to freeze. The manufacturer's instructions for Novolog dated October 2021, indicated unopened pens should be stored in the refrigerator between 36 to 46 degrees F. The licensee's Storage of Medications policy dated August 1, 2021, noted medications would be handled and stored per acceptable standards. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced	01890		

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01890	Continued From page 35 by: Based on observation, interview, and record review, the licensee failed to ensure medications were maintained bearing the original prescription label with legible information including the expiration date for time sensitive medications for two of three residents (R1, 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On June 5, 2023, at 1:57 p.m., the surveyor reviewed the locked medication closet with clinical nurse supervisor (CNS)-B. CNS-B observed and confirmed the following: TIME SENSATIVE MEDICATIONS R1's opened Lantus 100 units/milliliter (ml) and Novolog 100 units/ml insulin pens (a multiple dose pen shaped injector device for insulin administration) did not have a label which indicated the date the pens had been opened and when the pens would expire. On June 5, 2023, at 2:00 p.m., CNS-B stated all insulin pens should be dated when they are put into use. ORIGINAL PRESCRIPTION LABEL R2's two (2) unlabeled preset 0.5 ml syringes were in a clear plastic baggie with the following information handwritten with black marker on the	01890		

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01890	Continued From page 36 outside of the plastic baggie, "Methadone 0.5". This preset medication lacked an original prescription label with information regarding the directions for use, medication dosage, resident's name, and the pharmacy in which it had been issued. R2's two (2) unlabeled preset 0.75 ml syringes were in a clear plastic baggie with the following information handwritten with a black marker on the outside of the plastic baggie, "Haldol 0.75". This preset medication lacked an original prescription label with information regarding the directions for use, medication dosage, resident's name, and the pharmacy in which it had been issued. On June 5, 2023, at 2:07 p.m., CNS-B stated the above noted preset medications for R2 were not labeled with all the required content. The manufacturer's instructions for Lantus insulin pens dated May 2019, directed to discard the pen 28 days after it had been opened, even if it still had insulin left in it. The manufacturer's instructions for Novolog dated October 2021, directed to discard the pen 28 days after it had been opened, even if it still had insulin left in it. The licensee's Storage of Medication policy dated August 1, 2021, noted a legend drug must be kept in its original container bearing the original prescription label with legible information stating the prescription number, name of drug, strength and quantity of drug, expiration date of time-dated drug, directions for use, client's name, prescriber's name, date of issue and the name and address of the licensed pharmacy that issued	01890		

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01890	Continued From page 37 the medication. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01930 SS=F	144G.72 Subd. 2 Policies and procedures (a) An assisted living facility that provides treatment and therapy management services must develop, implement, and maintain up-to-date written treatment or therapy management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse or appropriate licensed health professional consistent with current practice standards and guidelines. (b) The written policies and procedures must address requesting and receiving orders or prescriptions for treatments or therapies, providing the treatment or therapy, documenting treatment or therapy activities, educating and communicating with residents about treatments or therapies they are receiving, monitoring and evaluating the treatment or therapy, and communicating with the prescriber. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop, implement, and maintain up-to-date written treatment or therapy management policies and procedures that were developed under the supervision and direction of a registered nurse (RN) consistent with current practice standards and guidelines.	01930		

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01930	Continued From page 38 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: During the entrance conference on June 5, 2023, at 1:35 p.m., clinical nurse supervisor (CNS)-B stated the licensee provided treatment and therapy services to residents at the facility. On June 6, 2023, at 9:20 a.m., the surveyor observed unlicensed personnel (ULP)-C conduct R1's blood glucose monitoring check. The treatment and therapy policies provided did not include policies to address the following: - educating and communicating with residents about treatments or therapies they receiving - monitoring and evaluating the treatment or therapy, and - communicating with the prescriber On June 7, 2023, at 10:36 a.m., clinical nurse supervisor (CNS)-B stated the above noted treatment and therapy policies had not been developed. No further information was provided. TIME PERIOD OF CORRECTION: Twenty-One (21) days	01930		

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01940	Continued From page 39	01940		
01940 SS=D	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 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 one of two	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	38206		06/07/2023

NAME OF PROVIDER OR SUPPLIER

FAMILY TREE CARE HOMES LLC

STREET ADDRESS, CITY, STATE, ZIP CODE

3233 RICHMOND AVENUE
SHOREVIEW, MN 55126

(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
01940	Continued From page 40 residents (R2) who had treatments managed by 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, 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: During the entrance conference on June 5, 2023, at 1:35 p.m., clinical nurse supervisor (CNS)-B stated the licensee provided treatment and therapy services to residents at the facility. R2's diagnoses included hypertension, chronic kidney disease and heart failure (condition in which the heart's function as a pump is inadequate to meet the body's needs). R2's provider orders dated March 28, 2023, included an order for oxygen therapy 2 liters per nasal cannula (a thin flexible tube which on one end splits into two prongs that are placed in the nostrils and from which a mixture of air and oxygen flow) continuously. On June 6, 2023, at 8:25 a.m., the surveyor observed licensed assisted living director (LALD)-A and unlicensed personnel (ULP)-C reposition R2 in bed. R2 had an oxygen concentrator in the room set at 2 liters, however, R2's nasal cannula was not positioned in her nostrils. LALD-A stated R2 refused the oxygen most of the time and would let the staff know	01940		

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01940	Continued From page 41 when she wanted it on. R2's record did not include evidence of an individualized treatment management plan for R2's oxygen therapy which included: - a written statement on the service plan of the treatment or therapy services that will be provided to the resident; and - identification of treatment or therapy tasks that would be delegated to unlicensed personnel for oxygen therapy. On June 7, 2023, at 9:52 a.m., CNS-B stated R2's treatment and therapy management plan for oxygen therapy was incomplete as it did not include the above noted required content. The licensee's Delegation of Nursing Tasks policy dated January 6, 2023, noted when a treatment or therapy is delegated or assigned to ULP, the registered nurse or authorized licensed health professional must develop and maintain a current individualized treatment or therapy management record for each client. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
02310 SS=D	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards.	02310		

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02310	Continued From page 42 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the care and services were provided according to acceptable health care and medical, or nursing standards with regards to safely storing oxygen for one of two residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at 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 June 5, 2023, at 2:45 p.m., the surveyor toured the facility with licensed assisted living director (LALD)-A. LALD-A stated R3 may have oxygen stored in her room. The surveyor observed in R3's closet two small oxygen cylinders in the upright position leaning against the closet wall and boxes of briefs. These oxygen cylinders were not stored securely in a holder. On June 5, 2023, at 3:00 p.m., LALD-A stated he was unsure of how to properly store the oxygen cylinders. LALD-A stated R3's oxygen cylinders were not stored securely in a stand/holder. The Minnesota Department of Health (MDH) Oxygen Cylinder Storage Requirements dated April 16, 2020, based on the National Fire Protection Association, Standard 99 (NFPA 99), noted a common hazard in a health care facility is	02310		

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02310	Continued From page 43 storing and handling compressed oxygen in cylinders. When storing oxygen cylinders, they must be secured in racks or by chains to prevent them from falling over. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		
02410 SS=D	144G.91 Subd. 13 Personal and treatment privacy (a) Residents have the right to consideration of their privacy, individuality, and cultural identity as related to their social, religious, and psychological well-being. Staff must respect the privacy of a resident's space by knocking on the door and seeking consent before entering, except in an emergency or unless otherwise documented in the resident's service plan. (b) Residents have the right to have and use a lockable door to the resident's unit. The facility shall provide locks on the resident's unit. Only a staff member with a specific need to enter the unit shall have keys. This right may be restricted in certain circumstances if necessary for a resident's health and safety and documented in the resident's service plan. (c) Residents have the right to respect and privacy regarding the resident's service plan. Case discussion, consultation, examination, and treatment are confidential and must be conducted discreetly. Privacy must be respected during toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance. This MN Requirement is not met as evidenced	02410		

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02410	Continued From page 44 by: Based on observation, interview, and record review, the facility failed to ensure one of one resident (R1) was treated with dignity and respect when unlicensed personnel (ULP)-C provided treatment and medication management services to R1 in a public setting. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1's diagnoses included diabetes, generalized weakness and memory impairment. R1's service plan, Individualized Medication Management Plan, and Treatment or Therapy Management Plan dated December 9, 2022, indicated R1 received services to include blood glucose monitoring and medication administration. R1's prescriber orders dated December 9, 2022, included an order for blood glucose monitoring to be completed three times daily, and Lantus 30 units of insulin to be administered every morning. On June 6, 2023, at 9:20 a.m., R1 was seated at the kitchen counter/bar area next to R3. The surveyor observed ULP-C conduct R1's morning blood glucose check in the open kitchen/dining room area with R3 present. ULP-C proceeded to prepare R1's scheduled Lantus insulin pen at the	02410		

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02410	Continued From page 45 kitchen counter. R1 raised her shirt and lowered the front of her pant waist down exposing her lower abdomen. ULP-C administered R1's scheduled Lantus 30 units in R1's exposed lower abdominal area with R3 present. ULP-C did not encourage, offer, or attempt to assist R1 to a private area to perform the blood glucose check and/or administer R1's scheduled insulin. On June 6, 2023, at 9:52 a.m., ULP-C stated she had been trained on how to do blood glucose monitoring and insulin administration by clinical nurse supervisor (CNS)-B. ULP-C stated it wasn't covered in the training that it should be done in private, but "I understand why it should be". ULP-C stated she had conducted R1's blood glucose check and administered R1 her morning insulin in a nonprivate area with R3 present. On June 6, 2023, at 10:06 a.m., CNS-B stated blood glucose checks and insulin administration should be conducted in a private area. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02410		

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

Type: Full
Date: *06/05/23*
Time: 14:05:27
Report: 1021231153

Food and Beverage Establishment Inspection Report

Location:
Family Tree Care Homes
3233 Richmond Ave
Shoreview, MN55126
Ramsey County, 62

Establishment Info:
ID #: N038206
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #:
ID #:

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

The following orders were issued during this inspection.

7-200 Toxic Supplies and Applications

7-204.11 ***** Priority 1 *****

MN Rule 4626.1620 Discontinue using chemical sanitizers, including chemical sanitizing solutions generated on site and other chemical antimicrobials on food-contact surfaces that do not meet the requirements specified in 40 CFR part 180, section 180.940, or part 180, subpart E, section 180.2020.

THE BLEACH CONCENTRATION IN SANI SPRAY BOTTLE MEASURED GREATER THAN 200PPM. SANI SPRAY BOTTLE WAS CORRECTED ON-SITE TO A CONCENTRATION OF 100PPM.

Comply By: 06/05/23

4-300 Equipment Numbers and Capacities

4-302.14 ***** Priority 2 *****

MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.

NO TEST KIT ON-SITE TO MEASURE THE CONCENTRATION OF BLEACH. PROVIDE.

Comply By: 06/09/23

6-300 Physical Facility Numbers and Capacities

6-301.14A

MN Rule 4626.1457 Provide a sign or poster at all handwashing sinks used by food employees that notifies them to wash their hands

HANDWASHING SINKS IN THE KITCHEN AND BATHROOMS ARE MISSING HAND WASHING SIGNS OR POSTERS THAT REMIND FOOD EMPLOYEES TO WASH HANDS BEFORE RETURNING TO WORK. PROVIDE AS DESCRIBED IN RULE ABOVE.

Comply By: 06/09/23

Surface and Equipment Sanitizers

Food and Beverage Establishment Inspection Report

Chlorine: > 200PPM at Degrees Fahrenheit
Location: SANI SPRAY BOTTLE
Violation Issued: Yes

Chlorine: = 100PPM at Degrees Fahrenheit
Location: SANI SPRAY BOTTLE *CORRECTED
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 39 Degrees Fahrenheit - Location: MILK - LG REFRIGERATOR
Violation Issued: No

Process/Item: Cold Holding
Temperature: 40 Degrees Fahrenheit - Location: EGG SALAD - LG REFRIGERATOR
Violation Issued: No

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

ALL FINDINGS ON THIS REPORT WERE DISCUSSED WITH DIRECTOR, LEE PANZER AND HEALTH REGULATION DIVISION NURSE EVALUATOR, JANA BROMENSHENKEL.

THIS FACILITY IS A RESIDENTIAL HOME KITCHEN. THEY CURRENTLY HAVE 3 CLIENTS AND CAN HAVE UP TO 5 CLIENTS.

PER CONVERSATION WITH LEE, FOOD IS MADE FOR SAME DAY SERVICE. NO LEFTOVERS ARE KEPT.

THE KITCHEN HAS RESIDENTIAL EQUIPMENT, WOOD FLOORING AND TEXTURED CEILING. PHYSICAL FACILITY ITEMS WILL BE MONITORED AT FUTURE INSPECTIONS.

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 1021231153 of 06/05/23.

Certified Food Protection Manager: LEE J. PANZER

Certification Number: FM97525 Expires: 02/27/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
LEE PANZER
DIRECTOR

Signed: _____
Melissa Ramos
Environmental Health Specialist
Metro District Office
651-201-4495
Melissa.Ramos@state.mn.us