Electronically Delivered

August 22, 2022

Administrator
Hometown Senior Living of Eagan
3808 Blackhawk Ridge Place
Eagan, MN 55122

RE: Project Number(s) SL25900015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on June 14, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health 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.

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

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

Level 1: no fines or enforcement.
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

In accordance with Minn. Stat. § 144G.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation

that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The Department of Health also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5)(b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, no immediate fines are assessed.

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up evaluations. The licensee is not required to submit a plan of correction 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 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 licensing 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 general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

Please address your cover letter for general reconsideration requests to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place

Free from Maltreatment reconsideration requests should be addressed to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place

St. Paul, MN 55164-0970 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 this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,

Paul Spencer, Supervisor
State Rapid Response Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64970
St. Paul, MN 55164-0970
Telephone: 651-201-4222 Fax: 651-281-9796

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25900	A. BUILDING: _____ B. WING _____	06/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMETOWN SR LIVING OF EAGAN	3808 BLACKHAWK RIDGE PLACE EAGAN, MN 55122

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0 000	Initial Comments 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: SL25900015 On, June 13, 2022, through June 14, 2022, 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 seven (7) residents, all of whom received services under the provider's Assisted Living 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 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (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, and interview, 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 13, 2022, for the specific Minnesota Food Code deficiencies.	0 480		

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0 490	Continued From page 2	0 490		
0 490 SS=F	144G.41 Subd 1 (13) (ii)-(vii) Minimum requirements (ii) weekly housekeeping; (iii) weekly laundry service; (iv) upon the request of the resident, provide direct or reasonable assistance with arranging for transportation to medical and social services appointments, shopping, and other recreation, and provide the name of or other identifying information about the persons responsible for providing this assistance; (v) upon the request of the resident, provide reasonable assistance with accessing community resources and social services available in the community, and provide the name of or other identifying information about persons responsible for providing this assistance; (vi) provide culturally sensitive programs; and (vii) have a daily program of social and recreational activities that are based upon individual and group interests, physical, mental, and psychosocial needs, and that creates opportunities for active participation in the community at large; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to have daily programs of social and recreational activities based on individual and group interests, physical, mental, and psychosocial needs, which create opportunities for active participation in the community at large. This had the potential to affect all seven residents of the facility.	0 490		

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0 490	Continued From page 3 This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client'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 clients). The findings include: During a facility tour on June 13, 2022, at 10:45 a.m., the surveyor did not observe recreation or daily program of social activities posted in a common area. For the duration of the survey from June 13, 2022, through June 14, 2022, the surveyor did not observe programs of social or recreational activities provided by the licensee. During an interview on June 14, 2022, 2:00 p.m., executive director of operations (ED)-F confirmed with the lead resident assistant that no daily programs of social and recreational activities had been posted for the current week. The ED-F also stated staff usually do individual activities with residents. The licensee's Activity Programming policy, dated August 1, 2021, indicated a monthly activity calendar will be created and available to all residents. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 490		

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0 510	Continued From page 4	0 510		
0 510 SS=C	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to establish and maintain an infection control program that complies with accepted health care, medical and nursing standards for infection control related to COVID-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 all four residents). Findings include: Centers for Disease Control and Prevention's Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes & Long-Term Care Facilities, updated February 2, 2022, recommends having a plan for visitation. The	0 510		

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0 510	Continued From page 5 CDC recommends posting signs at entrances reminding of the importance of remaining up to date with all recommended COVID-19 vaccine doses and visitors should not visit if they have a positive viral test for SARS-CoV-2, symptoms of COVID-19 or close contact with someone with SARS-CoV-2 infection. The surveyor observed the licensee lacked signs at the entrance indicating visitors needed to wear masks or needed COVID-19 screening to enter the building. During an email correspondence on June 16, 2022, at 12:38 p.m., the executive administrative assistant responded to the surveyor's request for policies specific to COVID with "we follow the CDC guidelines". Time Period to Correct: Seven (7) Days	0 510		
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal.	0 580		

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0 580	Continued From page 6 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to engage in and maintain documentation on quality management activities appropriate to the size of the facility and relevant to the type of services provided. This had the potential to affect all residents. 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: During the entrance conference on June 13, 2022, at 10:30 a.m., director of operations (DOO)-D stated she was not sure what quality management consisted of and to check with the registered nurse about it. During an interview on June 14, 2022, at approximately 2:00 p.m., executive director of operations (ED)-F provided the MDH surveyor with a document titled 2014 Provider Quality Improvement Tool with a start date of June 30, 2015. The ED-F stated that was the most recent quality management project that they had worked on. The licensee's Quality Management Project policy, dated August 1, 2021, indicated the licensee will have at least one documented quality management project in place at all times,	0 580		

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0 580	Continued From page 7 and retain records of such projects for at least two years. Also, the policy indicated at least one performance improvement project needs to be in process at all times. TIME PERIOD TO CORRECT: Twenty-one (21) Days	0 580		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to post the 911 emergency number in common areas and near telephones. This had the potential to affect all residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems	0 640		

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0 640	Continued From page 8 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: During a tour of the facility on June 13, 2022, at 10:45 a.m., MDH surveyor observed there were no required postings of the 911 emergency number in common areas and near telephones. During an interview on June 14, 2022, at 3:00 p.m., executive director of operations (ED)-F stated they had not posted a sign with 911 next to the telephones yet. The licensee's Vulnerable Adult Maltreatment-Prevention & Reporting policy, dated August 1, 2021, indicated the facility will support protection and safety through access to the states's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by posting the 911 emergency number in common areas and near telephone provided by the assisted living facility. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 640		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (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	0 680		

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0 680	Continued From page 9 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 tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop an emergency preparedness plan (EPP) with all the required components included in Appendix Z. This had the potential to affect all residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). Findings include: During the assisted living facility survey entrance	0 680		

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0 680	Continued From page 10 conference on June 13, 2022, at approximately 10:30 a.m., director of operations (DOO)-D stated she was not familiar with Appendix Z. During an interview on June 14, 2022, at 9:30 a.m., executive director of operations (ED)-F acknowledged they did not have all the required components of Appendix Z. The registered nurse (RN)-E provided the surveyor with a document titled Fire and Emergency Evacuation Plan. The licensee's Fire and Emergency Evacuation Plan lacked the following required content: -establish the Emergency Program (EP) -develop and maintain EP -maintain and annual EP updates -EP patient population -process for EP collaboration -development of EP policies and procedures -subsistence needs for residents and staff -procedure for tracking residents and staff -policies and procedures including evacuation -policies and procedures for sheltering -policies and procedures for medical documents -policy and procedures for volunteers -arrangement with other facilities -roles under a waiver declared by Secretary -development of communication plan -names and contact information -emergency officials contact information -primary/alternate means of communication -methods for sharing information -sharing information on occupancy/needs -family notifications -EP prep training and testing -EP prep training program -EP prep testing requirements The licensee's Disaster Planning and Emergency	0 680		

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0 680	Continued From page 11 Preparedness policy, dated August 1, 2021, indicated the licensee will have in place a emergency preparedness plan that is in alignment with facility's requirement to comply with CMS Appendix Z. Also, the licensee's Emergency Preparedness Plan- Appendix Z Compliance policy, dated August 1, 2021, indicated it is the intent that Hometown Senior Living has in place an effective and compliant Emergency Preparedness Plan. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code,	0 780		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 780	Continued From page 12 except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview the licensee failed to provide smoke alarms through-out and ensure smoke alarms are interconnected so that actuation of one alarm causes all alarms in the dwelling to actuate as required. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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 residents). The findings include: On 06/14/2022, between 1:00 pm and 2:30PM, survey staff toured the facility with HM-C. During the facility tour, survey staff observed smoke detector's on the main floor are dated 2008 and have exceed ten years from date of manufacture. HM-C verbally confirmed survey staff observations during the facility tour. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days or Seven (7) days	0 780		

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	25900	A. BUILDING: _____ B. WING _____	06/14/2022

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0 790	Continued From page 13	0 790		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure installation and maintenance of portable fire extinguishers at the facility. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation and was issued at a widespread scope. The findings include: On 06/14/2022, from approximately 1300 to 1430, survey staff toured the facility with HM-C. During the facility tour, survey staff observed that the fire extinguisher were not checked on a monthly base. HM-C verbally confirmed survey staff observations during the facility tour. The adminstrator stated they did not know they were to do this inspection monthly.	0 790		

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0 790	Continued From page 14 No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days or Twenty-one (21) days	0 790		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of 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	0 810		

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0 810	Continued From page 15 activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to provide the required fire safety training and evacuation plans for residents and staff. This has the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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 the potential to affect a large portion or all residents). The findings include: On 06/14/2022, from approximately 1:00pm to 2:30pm, survey staff toured the facility with HM-C. During the facility tour, survey staff observed deficiencies in Fire Safety & Evacution plans as the follwing: 1. Fire drills for 2021 all were completed on day shaft only. 2. Fire drills for 2022 were only completed in the month of May only. 3. Floor plan did not show evacuation routes out of each bedroom. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7)	0 810		

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0 810	Continued From page 16 days or Twenty-one (21) days	0 810		
01370 SS=F	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's	01370		

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01370	Continued From page 17 family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure training and competency was completed for one of two employees, unlicensed personnel (ULP)-B to include all required content with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-B was hired on April 10, 2019, under the comprehensive home care license and began providing assisted living services on August 1, 2021. ULP-B's employee file lacked documentation of training and competency evaluations for the following topics: -training on the prevention of falls; -standby assistance techniques and how to perform them; -medication, exercise, and treatment reminders; -basic nutrition, meal preparation, food safety, and assistance with eating;	01370		

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01370	Continued From page 18 -preparation of modified diets as ordered by a licensed health professional; -communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; -awareness of confidentiality and privacy; -awareness of commonly used health technology equipment and assistive devices. During an interview on June 14, 2022, at approximately 3:00 p.m., executive director of operations (ED)-F confirmed ULP-B's file lacked documentation of training and competency on the required topics listed above. The licensee's Competency Training Evaluations policy dated August 1, 2021, indicated when a registered nurse or licensed health professional staff of Hometown Senior Living delegates tasks, prior to the delegation of services they must make certain the unlicensed personnel is trained in the proper methods to perform the tasks or procedures for each client and are able to demonstrate the ability to competently follow the procedures and perform the tasks. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		
01460 SS=F	144G.63 Subdivision 1 Orientation of staff and supervisors All staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. The orientation may be incorporated into the training required under subdivision 5. The	01460		

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01460	Continued From page 19 orientation need only be completed once for each staff person and is not transferable to another facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure orientation to assisted living licensing requirements and regulations was provided for two of two employees, certified nursing assistant (CNA)-A and unlicensed personnel (ULP)-B, with records reviewed. This had the potential to affect all residents receiving assisted living services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: CNA-A was hired July 16, 2021, and began providing assisted living services to licensee's residents on August 1, 2021. ULP-B's employee training records lacked evidence of successful completion of assisted living orientation in accordance with 144G statutes. ULP-B was hired on April 10, 2019, under a comprehensive home care license. ULP-B began providing assisted living services on August 1, 2021. ULP-B's employee training records lacked evidence of successful completion of assisted living orientation in accordance with 144G statutes.	01460		

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01460	Continued From page 20 During an interview on June 14, 2022, at approximately 3:00 p.m., executive director of operations (ED)-F acknowledged ULP-B's orientation checklist was specific to home care regulatory requirements. The licensee's Orientation of Staff and Supervisor & Content policy, dated August 1, 2021, indicated all staff of Hometown Senior Living providing and supervising direct services must complete an orientation to Assisted Living facility licensing requirement and regulations before providing assisted living services to residents. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	01460		
01470 SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct	01470		

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01470	Continued From page 21 support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the	01470		

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01470	Continued From page 22 licensee failed to ensure orientation to assisted living facility statutes included all the required content for two of two employees, certified nursing assistant (CNA)-A and unlicensed personnel (ULP)-B with records reviewed. 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: CNA-A was hired July 16, 2021. As of August 1, 2021 the facility began operation under the assisted living licensure under 144G statutes. CNA-A began providing assisted living services to licensee's residents on August 1, 2021. CNA-A's employee training records lacked evidence of successful completion of assisted living orientation in accordance with 144G statutes. ULP-B was hired April 10, 2019, under the comprehensive home care license. As of August 1, 2021 the facility began operation under the assisted living licensure under 144G statutes. ULP-B began providing assisted living services to licensee's residents on August 1, 2021. ULP-B's employee training records lacked evidence of successful completion of assisted living orientation in accordance with 144G statutes. CNA-A's employee training records lacked evidence of successful completion of assisted living orientation in accordance with 144G	01470		

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01470	Continued From page 23	01470		

statutes, including the following content:
-an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person;
-compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC);
-handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints;
-consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and
-a review of the types of assisted living services the employee will be providing and the facility's category of licensure.

ULP-B's employee training records lacked evidence of successful completion of assisted living orientation in accordance with 144G statutes, including the following content:
-an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person;
-handling of emergencies and use of emergency services;
-compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC);
-the assisted living bill of rights and staff responsibilities related to ensuring the exercise

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01470	Continued From page 24	01470		

and protection of those rights;
-the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person;
-handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints;
-consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and
-a review of the types of assisted living services the employee will be providing and the facility's category of licensure.

The licensee's Orientation of Staff and Supervisors & Content policy, dated August 1, 2021, indicated all Hometown Senior Living employees must complete the orientation to assisted living facility requirement before providing assisted living service to residents and the orientation must contain the following topics:
-An overview of the appropriate Assisted Living statutes and rules
-An introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person
-Handling of emergencies and use of emergency services
-Compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC)
-The assisted living bill of rights and staff responsibilities related to ensuring the exercise

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01470	Continued From page 25 and protection of those rights -Principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person -Handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints -Consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services -A review of the types of assisted living services the employee will be providing and the facility's category of licensure -The staff person's job description upon hire and whenever there is a change to the job description that changes the nature of the job or how the job is to be performed -The facility's organization chart and the roles of staff within the facility, and the services offered by the facility as identified in the uniform checklist disclosure of services -The identification of incidents of maltreatment as defined under Minnesota Statutes, section 626.5572, subdivision 15, including abuse, financial exploitation, and neglect, and an explanation that any act that constitutes maltreatment is prohibited TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	01470		
01790 SS=F	144G.71 Subd. 10 Medication management for residents who will	01790		

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HOMETOWN SR LIVING OF EAGAN	3808 BLACKHAWK RIDGE PLACE EAGAN, MN 55122

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01790	Continued From page 26 (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the	01790		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25900	A. BUILDING: _____ B. WING _____	06/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMETOWN SR LIVING OF EAGAN	3808 BLACKHAWK RIDGE PLACE EAGAN, MN 55122

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01790	Continued From page 27 medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) developed training and competencies for providing medications to residents for unplanned time away from home when the licensed nurse was not available for two of two employees, certified nursing assistant (CNA)-A and unlicensed personnel (ULP)-B with record reviewed. 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).	01790		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25900	A. BUILDING: _____ B. WING _____	06/14/2022

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01790	Continued From page 28 The findings include: CNA-A had a hire date of July 16, 2021. CNA-A's record lacked documentation of training and competencies for unplanned time away when the RN is not available. ULP-B had a hire date of April 10, 2019. ULP-B's record lacked documentation of training and competencies for unplanned time away when the RN is not available. During an interview on June 14, 2022, at approximately 11:00 a.m., executive director of operations (ED)-F stated she was positive that the employees had been trained on unplanned time away and would "double check" with HR to see if documentation was located elsewhere. The licensee's Medication Management- Planned & Unplanned Time Away policy, dated August 1, 2021, indicated for unplanned resident time away when a pharmacist or licensed nurse is not available, the RN may delegate this task to unlicensed personnel if the RN has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors Subd. 8.Notice to visitors. (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring	03090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25900	A. BUILDING: _____ B. WING _____	06/14/2022

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03090	Continued From page 29	03090		

devices, including security cameras and audio devices, may be present to record persons and activities."

(b) The facility is responsible for installing and maintaining the signage required in this subdivision.

This MN Requirement is not met as evidenced by:
Based on observation and interview, the licensee failed to ensure a required notice was posted at the main entry way of the licensee's facility to display statutory language to disclose electronic monitoring activity. This had the potential to affect all residents, staff, and visitors to the facility.

This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).

The findings include:

On June 13, 2022, at approximately 9:30 a.m., the Minnesota Department of Health (MDH) surveyor entered the facility and observed no electronic monitoring notice posted at the entrance to the licensee's facility.

During an exit conference and interview on June 14, 2022, at 3:00 p.m., executive director of operations (ED)-F acknowledged the licensee failed to post the required electronic monitoring notice but stated the required notice would be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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03090	Continued From page 30 posted. The licensee's policy Electronic Monitoring dated August 1, 2021, indicated that signs are installed at each facility entrance accessible to visitors that state: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons or activities." TIME PERIOD FOR CORRECTION: Twenty-one (21) days	03090		

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

Type: Full
Date: *06/13/22*
Time: 10:30:00
Report: 1005221054

Food and Beverage Establishment Inspection Report

Location:
Hometown Sr Living Of Eagan
3808 Blackhawk Ridge Place
Eagan, MN55122
Dakota County, 19

Establishment Info:
ID #: 0037650
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 6517147075
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.

3-500A Microbial Control: cooling

3-501.14A ** Priority 1 **

MN Rule 4626.0385A Cool cooked TCS food: 1. within 2 hours from 135 degrees F (57 degrees C) to 70 degrees F (21 degrees C); and 2. within a total of 6 hours from 135 degrees F (57 degrees C) to 41 degrees F (5 degrees C) or less.

GOULASH THAT WAS PREPARED THE NIGHT BEFORE WAS STILL 50 DEGREES F. GOULASH WAS DISCARDED.

Comply By: 06/13/22

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.

EMPLOYEE'S SERVSAFE CERTIFICATE WAS ON SITE, BUT SHE IS NOT REGISTERED AS A MN CFPM. FACT SHEET LEFT ON SITE.

Comply By: 07/13/22

4-200 Equipment Design and Construction

4-201.11GMN

MN Rule 4626.0506G Discontinue serving TCS foods that are held for more than same-day service in an adult or child care center or boarding establishment or provide equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.

GOULASH THAT WAS PREPARED THE NIGHT BEFORE HAD IMPROPERLY COOLED AND WAS DISCARDED. DISCUSSED THAT UNLESS COMMERCIAL EQUIPMENT IS PROVIDED, MEALS MUST BE PREPARED FOR SAME-DAY SERVICE.

Comply By: 06/13/22

Surface and Equipment Sanitizers

Utensil Surface Temp.: = at 160+ Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Hold/MILK
Temperature: 39 Degrees Fahrenheit - Location: KITCHEN, "FRIDGE 1"
Violation Issued: No

Process/Item: Cold Hold/ROAST BEEF
Temperature: 34 Degrees Fahrenheit - Location: KITCHEN, "FRIDGE 1"
Violation Issued: No

Process/Item: Cold Hold/LETTUCE
Temperature: 37 Degrees Fahrenheit - Location: KITCHEN, "FRIDGE 1"
Violation Issued: No

Process/Item: Cooling/GOULASH
Temperature: 50 Degrees Fahrenheit - Location: KITCHEN, "FRIDGE 1", FROM LAST NIGHT
Violation Issued: Yes

Process/Item: Cold Hold/YOGURT
Temperature: 40 Degrees Fahrenheit - Location: GARAGE, "FRIDGE 2"
Violation Issued: No

Process/Item: Cold Hold/CHEESE
Temperature: 39 Degrees Fahrenheit - Location: GARAGE, "FRIDGE 3"
Violation Issued: No

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

INSPECTION COMPLETED WITH HOME MANAGER, DAWN CLARK, AND REVIEWED WITH HRD NURSE EVALUATOR, STACIA HANSEN.

DISCUSSED ORDERS ON REPORT, AS WELL AS GLOVE USE, EMPLOYEE ILLNESS, AND DATE MARKING.

DISCUSSED THAT COOKING AND COOLING OF MEALS IS NOT ALLOWED WITH RESIDENTIAL EQUIPMENT, AND ALL MEALS MUST BE PREPARED SAME DAY.

AFTER INSPECTION, MANAGER SENT INSPECTOR A PICTURE OF A THERMOLABEL THEY RAN THROUGH THEIR DISHWASHER, WHICH SHOWED THAT IT WAS PROVIDING A UTENSIL SURFACE TEMPERATURE OF AT LEAST 160 DEGREES F NEEDED TO SANITIZE.

FACILITY HAS POPCORN CEILINGS AND HOLLOW, ENCLOSED BASES FOR
THE CABINETS. NEITHER OF THESE ARE APPROVED, BUT ARE CLEAN AND IN GOOD REPAIR AT THIS TIME. CEILING AND CABINETS WILL BE MONITORED AT FUTURE INSPECTIONS.

Food and Beverage Establishment Inspection Report

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 1005221054 of 06/13/22.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /

Inspection report reviewed with person in charge and emailed.

Signed:_____
DAWN CLARK
HOME MANAGER

Signed:_____
Jessica Davis
Public Health Sanitarian III
651-201-3961
jessica.davis@state.mn.us