Electronically Delivered

July 1, 2025

Licensee
Parkinson's Specialty Care
6804 Dovre Drive Edina
Edina, MN 55436

RE: Project Number(s) SL32015017

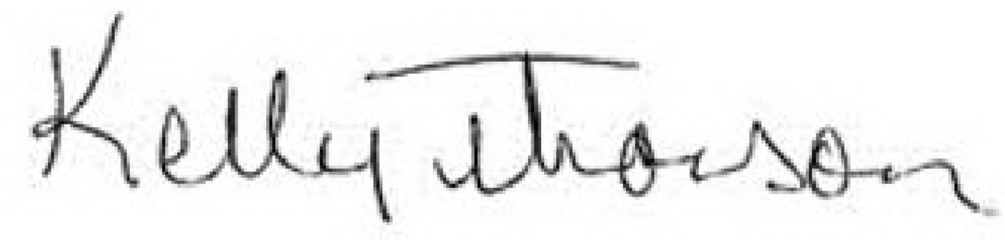
Dear Licensee:

On June 12, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on March 28, 2025. 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,



Kelly Thorson, Supervisor
State Evaluation Team
Email: Kelly.Thorson@state.mn.us
Telephone: 320-223-7336 Fax: 1-866-890-9290

HHH

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May 12, 2025

Licensee
Parkinson's Specialty Care
6804 Dovre Drive
Edina, MN 55436

RE: Project Number(s) SL32015017

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on March 28, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

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

St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - $3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $3,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

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

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,

Jess Schoenecker, Supervisor
State Evaluation Team
Email: Jess.Schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32015	A. BUILDING: _____ B. WING _____	03/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKINSON'S SPECIALTY CARE	6804 DOVRE DRIVE EDINA MN 55436 EDINA, MN 55436

(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 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: Project # SL32015017 On March 24, 2025, through March 28, 2025, 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 eleven (11) residents receiving services under the Assisted Living License. On March 25, 2025, an immediate order was issued for tag identification 2310. During the course of the survey, the licensee took action to mitigate the imminent risk. Noncompliance remained and the scope and level remain unchanged.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for	0 470		

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0 470	Continued From page 1 determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and post the staffing plan for residents, staff, and visitors to review as required. 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	0 470		

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0 470	Continued From page 2 cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee failed to develop and implement a staffing plan for determining its staffing level based on the following: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility. (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility. - include direct-care staff work schedules for each direct-care staff member showing all work shifts, including days and hours worked - identify the direct-care staff member's resident assignments or work location - be posted after redacting direct-care staff member's resident assignments, at the beginning of each work shift in a central location in each building On March 24, 2025, at 11:30 a.m., no posted staff schedule was observed in any area of the facility. On March 26, 2025, at 11:00 a.m., clinical nurse supervisor (CNS)-A stated a staff plan was not developed to always ensures sufficient staffing to meet the scheduled and no staffing schedule had	0 470		

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0 470	Continued From page 3 been posted as required. CNS-A stated they have a daily staffing schedule, but it was not posted. CNS-A stated that the plan was to have two unlicensed personnel (ULP) per house. Also, CNS-A mentioned that the owners were responsible for developing the staffing plan and CNS-A confirmed that she had not reviewed the staffing plan with the owner. The licensee Staffing, Direct-Care Staffing Plan & Daily Schedule policy dated July 29, 2021, indicated "A clinical nurse supervisor, or designee, will develop, write, and implement a staffing plan. The staffing plan will provide qualified direct-care staff sufficient to meet the residents' needs 24-hours a day, seven-days a week and will be adequate to address: a. Each resident's needs as identified in the service plan and assisted living contract b. Each resident's acuity level as determined by the most recent assessment or individualized review c. Ability to meet the residents' scheduled and reasonably unforeseeable unscheduled needs given the physical layout of the facility premises d. The staffing plan will indicate if the assisted living has a secured dementia care unit e. Staff competency and training." No further information was provided. TIME PERIOD FOR CORRECTION: Two days (2) days	0 470		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food	0 480		

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

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0 480	Continued From page 5 and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated March 24, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		

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0 580 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. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to engage in and maintain documentation of a quality management activity. 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, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On March 24, 2025, at 10:30 a.m., during the entrance conference with clinical nurse supervisor (CNS)-A and licensed assisted living	0 580		

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0 580	Continued From page 7 director (LALD)-C, a request was made to review documentation of the licensee's quality management activities. On March 27, 2025, at 1:40 p.m., the email received from human resources (HR)-G indicated that a meeting took place on August 20, 2024, and HR-G stated "this is all I could find at the moment." However, the licensee had not provided details on what was discussed or shared quality improvement meeting minutes with the surveyor. The licensee's Quality Management Plan policy dated August 1, 2021, indicated "The Assisted Living Director will establish a quality management program to develop and maintain the agency's continuous performance improvement efforts. The Quality Council meetings will be held at least quarterly to evaluate the quality of care. Quality Council meeting minutes will be retained for two-years and will be made available to the commissioner at the time of survey, investigation, or renewal." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 580		
0 630 SS=E	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults;	0 630		

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0 630	Continued From page 8 and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include statements of the specific measures to be taken to minimize the risk of abuse for two of two residents (R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a 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: R2 R2's admitted September 22, 2022, with diagnoses that included but were not limited to Parkinson's disease. R2's Service Plan dated September 23, 2022, indicated R2 received assistance with medication administration, assistance with dressing and grooming, bathing, gastrostomy (G-tube) flush, vital signs, and behavior management. R2's 90-day (Nursing) assessment dated February 19, 2025, completed by licensed	0 630		

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0 630	Continued From page 9 practical nurse (LPN)-D, indicated R2 was not at risk to be abused. R2's IAPP dated February 19, 2025, indicated R2 was not at risk to be abused. R2's record lacked an IAPP to include the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. R3 R3's admitted February 27, 2025, with diagnoses that included but were not limited to diabetes. R3's unsigned Service Plan with effective date March 12, 2025, indicated R3 received services which included medication administration, blood sugar checks, assistance with bathing, dressing, transfer, and toileting. R3's Admission (Nursing) assessment dated March 24, 2025, completed after the survey was initiated, indicated R3 was at risk to abuse other vulnerable adults. R3's record lacked an IAPP to include assessment of the person's susceptibility to abuse by another individual, and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. On March 26, 2025, at 12:30 p.m., clinical nurse supervisor (CNS)-A acknowledged R2 and R3's IAPPs were missing assessment for susceptibility to abuse by another individual, risk of abusing other vulnerable adults, and statements of the specific measures to be taken to minimize the	0 630		

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0 630	Continued From page 10 risk of abuse to that person and other vulnerable adults. CNS-A stated they will work to improve on their IAPP assessments and interventions. The licensee's Individual Abuse Prevention Plans Policy dated July 29, 2021, indicated "The individual abuse prevention plan will include: a. Individualized review or assessment of the resident's susceptibility to be abused by another individual, including other vulnerable adults b. The resident's risk of abusing other vulnerable adults c. Specific measures to minimize the risk of abuse to that person and other vulnerable adults. d. Measure to minimize the risk of self-abuse." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced	0 640		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKINSON'S SPECIALTY CARE	6804 DOVRE DRIVE EDINA MN 55436 EDINA, MN 55436

(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
0 640	Continued From page 11 by: Based on observation and interview, the licensee failed to support protection and safety by not posting information and phone numbers for reporting to the Minnesota Adult Abuse Reporting Center (MAARC) and failed to post the 911 emergency number in common areas and near telephones provided by the assisted living facility. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On March 24, 2025, at 11:30 a.m., the main entry area and common areas lacked the following required posted information: - posting of 911 emergency number in common areas and near telephones provided by the Assisted Living facility - posting of information and the reporting number for the MAARC to report suspected maltreatment of a vulnerable adult under section 626.557. On March 26, 2025, at 1:00 p.m., clinical nurse supervisor (CNS)-A stated the required content noted above had not been posted. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	0 640		

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0 640	Continued From page 12 days	0 640		
0 660 SS=E	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), which includes documentation of completion of a two-step TST (tuberculin skin test) or other evidence of TB screening such as a blood test for two of two employees (licensed practical nurse (LPN)-C, unlicensed personnel (ULP)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a	0 660		

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0 660	Continued From page 13 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: The licensee's TB facility risk assessment dated March 18, 2025, indicated the facility was a low risk for TB. ULP-B ULP-B was hired October 31, 2024, and provided direct cares for the residents of the facility. ULP-B's record included Baseline TB screening tool for health care worker (HCWs) dated November 8, 2024, and a QuantiFERON TB Gold plus (a blood test used to detect latent tuberculosis infection) dated April 3, 2024. LPN-C LPN-C was hired February 21, 2025, and provided direct cares for the residents of the facility. ULP-B's record included Baseline TB screening tool for health care worker (HCWs) dated February 25, 2025, and a QuantiFERON TB Gold plus (a blood test used to detect latent tuberculosis infection) dated July 10, 2024. ULP-B and LPN-C's employee records lacked evidence of a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. During an interview on February 26, 2025, at 1:00 p.m., human resources (HR)-G acknowledged	0 660		

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0 660	Continued From page 14 ULP-B and LPN-C's record missing a TST with negative results or a negative IGRA test within 90-days of hire. HR-G stated she thought TB test results were good for a year, and she was not aware of the required of a negative IGRA or TST dated within 90 days before hire. The licensee's TB Prevention And Control policy dated July 29, 2021, indicated "If a staff member presents a two-step Mantoux with negative results or a negative IGRA test within 90-days of hire, this will be used for proof of negative result and the staff member does not need further testing." The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and the CDC guidelines, indicated a TB infection control program should include a facility TB risk assessment. The guidelines also indicated an employee may begin working with patients after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW (health care worker) starts working with patients. Baseline TB screening should be documented in the employee's record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness	0 680		

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0 680	Continued From page 15 (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 interview and record review, the licensee failed to have a written emergency preparedness (EP) plan with all the required content. This had the potential to affect all current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems	0 680		

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0 680	Continued From page 16 are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee's Emergency and Disaster Preparedness with effective date August 1, 2021, indicated "Emergency Preparedness Plan is a work in progress" The licensee's plan lacked the following required content: - 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: - a description of the population served by the licensee; - procedure for tracking staff and residents; - subsistence needs for staff and residents during emergency situations; a written policy and procedure regarding missing residents - a communication plan that included: - arrangement with other facilities - names and contact information for resident physicians - contact information for federal, state, tribal, local EP staff, or the ombudsman - primary and alternative means for communicating with facility staff, or 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 occupancy; and -a method of sharing information from the	0 680		

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0 680	Continued From page 17 emergency plan with residents and their families. On March 26, 2025, at 1:00 p.m., clinical nurse supervisor (CNS)-A provided a document that indicated "Emergency Preparedness Plan is a work in progress" and CNS-A acknowledged the EP plan was missing the contents listed above. CNS-A stated they are aware of the required EP plan, but the last licensed assisted living director (LALD) was responsible to develop and implement EP plan, but the EP plan was missing customizations for the licensee. The licensee's Emergency and Disaster Preparedness policy with effective date August 1, 2021, indicated " The Emergency Preparedness Plan addresses the following requirements: (a) It is based on and includes a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. (b) Includes strategies for addressing emergency events identified by the risk assessment. (c) Addresses our resident population, including, but not limited to, persons at-risk; the type of services the facility has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans. (d) Includes a process for cooperation and collaboration with local, tribal, regional, State, or Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation. (e) The emergency disaster plan 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."	0 680		

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0 680	Continued From page 18 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the	0 730		

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0 730	Continued From page 19 needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident record included documentation of all provided services 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, 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: R3 admitted February 27, 2025, with diagnoses that included but were not limited to diabetes. R3's unsigned Service Plan with effective date March 12, 2025, indicated R3 received services	0 730		

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0 730	Continued From page 20 which included medication administration, blood sugar checks, assistance with bathing, dressing, transfer, and toileting. R3's Order Summary Report (physician order) signed February 27, 2025, indicated: -Novolog flex pen subcutaneous solution pen injector 100 unit/milliliter (ml) - inject 5 units subcutaneous three times a day; and -Insulin glargine subcutaneous solution pen injector 100 unit/ml - inject 12 units subcutaneous two times a day to treat diabetes (high blood glucose). R3's Vital sign -Blood Glucose from March 6, 2025, to March 27, 2025, indicated blood sugar levels were the following; - March 6 - 245 - March 7 - 216 - March 8 - 8: 00 a.m. - 193 and 12:00 p.m. - 192 - March 9 - 12:00 p.m. - 222 and 5:00 p.m. - 222 R3's record lacked blood glucose checks from February 28, 2025, to March 6, 2025. On March 28, 2025, at 10:49 a.m., clinical nurse supervisor (CNS)-A stated regarding R3's missing documentation "She came on February 28 at 11:00 a.m. Staff might have forgotten to chart." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730		
0 775 SS=E	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the	0 775		

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0 775	Continued From page 21 State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain compliance with Minnesota State Fire Code under Minnesota Rules Chapter 7511. This had the potential to affect some 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 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: On March 25, 2025, from approximately 1:04 p.m. to 3:00 p.m., the surveyor toured the facility with director of maintenance (DM)-G. During the tour, the surveyor observed the following deficient conditions: The window crank in West resident room 2 was not functional when DM-G attempted to open the window to measure for egress requirements. The crank was not securely attached and came loose from window assembly, and the window was not immediately openable. During the tour, DM-G was able to reattach the window crank and open the window. Window assemblies should be maintained in proper working condition such that egress windows are readily openable at all times.	0 775		

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0 775	Continued From page 22 Several multiplug adapters were in use in West resident room 4 to power appliances. The surveyor explained that these appliances should not be powered utilizing a multiplug adapter as they are not rated for that amount of draw and may pose a fire hazard. An extension cord was in use in West resident room 4 to power appliances. Extension cords should not be used in lieu of permanent wiring. Extension cords are not designed for sustained use and may pose risk of fire hazard. A multiplug adapter was in use in West resident room 2 to power appliances and electronics. The surveyor explained that these appliances should not be powered utilizing a multiplug adapter as they are not rated for that amount of draw and may pose a fire hazard. On March 25, 2025, the surveyor explained to DM-G the requirements to maintain egress windows assemblies and use of multiplug adapters. DM-G stated they understood requirements and would make appropriate changes. TIME PERIOD FOR CORRECTION: Two (2) days.	0 775		
0 780 SS=D	144G.45 Subd. 2 (a) (1) Fire protection and physical environment 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;	0 780		

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0 780	Continued From page 23 (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, 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 maintain required smoke alarms. 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) 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 March 25, 2025, from approximately 1:04 p.m. to 3:00 p.m., the surveyor toured the facility with director of maintenance (DM)-G. During the tour, the surveyor observed the following deficient	0 780		

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0 780	Continued From page 24 conditions: The hardwired smoke alarm provided in the laundry room on the East side of the facility was manufactured in 2010 based on information on the smoke alarm. Manufacturer instructions require replacing the smoke alarm after 10 years from manufacture date. Outdated smoke alarm in the laundry room should be replaced with a current hardwired smoke alarm. DM-G stated they were not aware of the age of the hardwired smoke alarm, but that they would have it replaced. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780		
0 800 SS=A	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 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 provide the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors.	0 800		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKINSON'S SPECIALTY CARE	6804 DOVRE DRIVE EDINA MN 55436 EDINA, MN 55436

(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
0 800	Continued From page 25 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 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 March 25, 2025, from approximately 1:04 p.m. and 3:00 p.m., the surveyor toured the facility with director of maintenance DM-G. During the tour the surveyor observed the following. The basement bathroom on the East side of the facility had flexible piping installed under the sink, which was not securely attached and appears to have leaked onto cabinet below. Plumbing should consist of approved rigid plumbing and be installed and maintained in proper manner including maintaining P-trap where required. DM-G verified the improper plumbing and made a note to have it replaced. During the facility tour interview on March 25, 2025, DM-G verified the above listed physical environment observation while accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
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:	0 810		

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0 810	Continued From page 26 (1) location and number of resident sleeping rooms; (2) staff 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) Staff 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 staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with required content and provide required training and documentation. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a	0 810		

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0 810	Continued From page 27 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 potential to affect a large portion or all of the residents). The findings include: On March 25, 2025, at approximately 2:30 p.m., licensed assisted living director (LALD)-C and director of maintenance (DM)-G provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training. The licensee FSEP failed to include the following: The FSEP did not include the location and number of resident rooms. No diagrams of the facility were included in the FSEP and diagrams provided throughout the facility on the walls did not include numbering or identification for resident room in the basement. The FSEP should include location and number of all resident rooms. The FSEP did not include any documentation of employee actions to be taken in event of fire or similar evacuation. LALD-C stated that no procedures have been developed for the facility. The facility also had markings on facility diagrams and signage above the garage designating it as a primary means of egress in an emergency. The garage should not be a designated means of egress as it is an area of higher hazard. Further there is a large lift on the stairs on the East side of the facility, which limits use of the stairs in an emergency. Facility evacuation diagrams avoided using these stairs as means of egress,	0 810		

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0 810	Continued From page 28 which is appropriate, however the limitations of the use of stairs during evacuation should be address in the employee procedures in the FSEP. Procedures for employee actions during an evacuation should be developed included in the FSEP. The FSEP did not include any fire procedures for residents. The FSEP did not address any unique or unusual resident needs for movement or evacuation. The FSEP should address any additional assistance or accommodations required for safe evacuation of residents. The FSEP did not include any record of staff training on the FSEP. LALD-C confirmed that training for staff has not been occurring but would develop such training. Staff must be trained to ensure they are familiar with proper procedures and are prepared in event that an evacuation is needed. Trainings on the FSEP should be provided to employees upon hire and at least twice a year thereafter. The FSEP did not include any documentation of trainings provided to residents on evacuation. Trainings should be made available to residents at least once a year. The FSEP did not contain any evidence of fire drills occurring for the facility. DM-G stated that the facility has not been conducting any drills and indicated understanding that it was improper to not be conducting evacuation drills. Evacuation drills are required at least twice a year per shift with at least one evacuation drill every other month.	0 810		

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0 810	Continued From page 29 During the record review and interview on March 25, 2025, DM-G and LALD-C verified the above listed documents were absent from the FSEP. The surveyor explained the requirements and importance of creating plans for evacuation for the facility, training staff, training resident and conducting drills. The surveyor indicated that the FSEP is largely deficient as most of the required documents are not present. DM-G and LALD-C stated that they understood requirements and would promptly develop and add the missing information and documents to the FSEP. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the licensee's liability for resident health, safety, or personal property. 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	0 970		

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0 970	Continued From page 30 a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's undated Assisted Living Contract included a section for Liability that read, "Provider is not liable to Resident ... for any injury, death or property damage occurring in the Private Room or on Provider'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 Resident... Resident agrees to hold Provider harmless from any and all claims for injuries, property damage or any other loss resulting from an accident or other occurrence in the Private Room or on Provider's premises." On March 26, 2025, at 12:30 p.m., clinical nurse supervisor (CNS)-A acknowledged the licensee's assisted living contract included the above content, and the same contract was utilized for all residents at the facility. CNS-A stated that they were aware of the problem with the liability language in the contract and they were working on removing the liability language in the contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
01370 SS=F	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn	01370		

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01370	Continued From page 31 (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 family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices.	01370		

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01370	Continued From page 32 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training, all required skill areas, and competency evaluations were completed by a registered nurse for two of two unlicensed personnel ((ULP)-B, ULP-F). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During entrance conference on March 25, 2025, at 11:00 a.m. CNS-A stated that a licensed practical nurse (LPN) does initial training and competency test for ULPs, and RN reviews training forms and sign it. ULP-B ULP-B was hired by the licensee on October 31, 2024, to provide assisted living services to the residents. ULP-B's Assisted Living and Competencies Manual indicated ULP-B was trained on November 8, 2024. However, no evidence of training and competency testing was completed by a registered nurse at that time. The same form was later signed by clinical nurse supervisor (CNS)-A on December 19, 2024.	01370		

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01370	Continued From page 33 ULP-F ULP-F was hired on August 8, 2024, to provide assisted living services to the residents. ULP-B and ULP-F's records lacked the following required competency testing conducted by a registered nurse: - 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; (iv) dressing and assisting with toileting; and - standby assistance techniques and how to perform them. From March 25, 2025, through March 26, 2025, the surveyor observed ULP-B and ULP-F workday shift providing direct care to the resident and assistance with medication administration. On March 26, 2025, at 11:00 a.m. ULP-B stated she was trained by LPN and not by a registered nurse. On March 26, 2025, at 1: 30 p.m., during interview CNS-A stated ULP-B and ULP-F trainings were completed by a LPN. CNS-A stated that she reviewed ULP-B's training forms and signed, but the LPN completed all the training in-person. Also, CNS-A stated LPNs were responsible to complete the initial competency testing for all ULPs, and CNS-A reviewed the document to make sure it was completed and then signed it. On March 28, 2025, at 2:30 p.m., via email CNS-A stated "The new plans propose utilizing Registered Nurses (RNs) to complete the initial	01370		

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01370	Continued From page 34 competency testing, 30-day supervision, 90-day training, and annual training for our staff. The plan is for new employees to first complete the care fundamentals and shadowing portions of their training, with the final step being competency testing administered by an RN." The licensees Assisted Living Orientation - ULP Staff policy dated August 1, 2021, indicated "Training and competency evaluations of unlicensed personnel providing assisted living services will be completed by a registered nurse. Another instructor may provide training in conjunction with a registered nurse." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		
01380 SS=F	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as	01380		

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01380	Continued From page 35 required. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training, all required skill areas, and competency evaluations were completed by registered nurse for two of two unlicensed personnel ((ULP)-B, ULP-F). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During entrance conference on March 25, 2025, at 11:00 a.m. CNS-A stated that a licensed practical nurse (LPN) does initial training and competency test for ULP's, and RN reviews training forms and sign it. ULP-B ULP-B was hired by the licensee on October 31, 2024, to provide assisted living services to the residents. ULP-B's Assisted Living and Competencies Manual indicated ULP-B was trained on November 8, 2024. However, no evidence of training and competency testing was completed by a registered nurse at that time. The same form was later signed by clinical nurse supervisor (CNS)-A on December 19, 2024.	01380		

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01380	Continued From page 36 ULP-F ULP-F was hired on August 8, 2024, to provide assisted living services to the residents. ULP-B and ULP-F's records lacked the following required competency testing conducted by a registered nurse: - reading and recording temperature, pulse, and respirations of the client; -safe transfer techniques and ambulation; - medication, exercise, and treatment reminders; -range of motioning and positioning; and -administering medications or treatments as required. From March 25, 2025, through March 26, 2025, the surveyor observed ULP-B and ULP-F workday shift providing direct care to the resident and assistance with medication administration. On March 26, 2025, at 11:00 a.m., ULP-B stated she was trained by a LPN and not by a registered nurse. On March 26, 2025, at 1: 30 p.m., during interview CNS-A stated ULP-B and ULP-F's trainings were completed by a LPN. CNS-A stated that she reviewed ULP-B's training record and signed, but the LPN completed all the training in-person. Also, CNS-A stated LPNs were responsible to complete the initial competency testing for all ULPs, and CNS-A reviews the document to make sure it was completed and signed it. On March 25, 2025, at 2: 30 p.m., via email CNS-A stated "The new plans propose utilizing Registered Nurses (RNs) to complete the initial competency testing, 30-day supervision, 90-day	01380		

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01380	Continued From page 37 training, and annual training for our staff. The plan is for new employees to first complete the care fundamentals and shadowing portions of their training, with the final step being competency testing administered by an RN." The licensees Assisted Living Orientation - ULP Staff policy dated August 1, 2021, indicated "Training and competency evaluations of unlicensed personnel providing assisted living services will be completed by a registered nurse. Another instructor may provide training in conjunction with a registered nurse." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380		
01470 SS=D	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct	01470		

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01470	Continued From page 38 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 staff member 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.	01470		

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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
01470	Continued From page 39 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employees received all required assisted living orientation content for one of two employees (licensed practical nurse (LPN)-D). 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: LPN-D was hired February 21, 2025, and provided direct care services to the licensee's residents. LPN-D"s employee records did not contain documentation of completed required assisted living licensing and regulation orientation content before providing assisted living services to residents which included: - an overview of Assisted Living laws 144G; - 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; - the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights;	01470		

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	32015	A. BUILDING: _____ B. WING _____	03/28/2025

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01470	Continued From page 40 - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person: and - handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints. On March 26, 2025, at 1: 30 p.m., human resources (HR)-G stated LPN-D's record was missing the required assisted living orientation content listed above. HR-G stated she assumed LPN-D's training was completed but it was an oversite. The licensee Assisted Living policy dated August 1, 2021, indicated "All assisted living employees must complete an orientation to assisted living facility licensing requirements and regulations before providing services to residents." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01470		
01610 SS=D	144G.70 Subd. 2 (a-b) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on	01610		

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01610	Continued From page 41 which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the registered nurse completed an initial, comprehensive nursing assessment prior to signing of assisted living contract or providing services 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, 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: R3 was admitted February 27, 2025, with diagnoses that included but were not limited to diabetes. R3's unsigned Service Plan with effective date March 12, 2025, indicated R3 received services which included medication administration, blood sugar checks, assistance with bathing, dressing, transfer, and toileting.	01610		

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01610	Continued From page 42 R3's Admission assessment (Nursing) dated March 7, 2025, and Admission assessment (Nursing) completed March 24, 2025, after the survey was initiated. R2's record lacked initial nursing assessment and monitoring must be conducted no more than 14 calendar days after initiation of services. On March 26, 2025, at 1:30 p.m., clinical nurse supervisor (CNS)-A stated R3's admission assessment and 14-day assessments were not done on time. CNS-A stated the licensee was going through staffing changes and was working on making the nursing assessment process better. The licensee's IAL And On-Going Nursing Assessment Of Residents policy dated August 1, 2021, indicated "Nursing assessments are completed by a registered nurse based upon the required assessment schedule and as needed based upon resident condition." No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01610		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days	01620		

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01620	Continued From page 43 from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to complete a change of condition reassessment when a resident returned from hospitalization for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include:	01620		

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01620	Continued From page 44 R2 was admitted September 22, 2022, with diagnoses that included but were not limited to Parkinson's disease. R2's Service Plan dated September 23, 2022, indicated R2 received assistance with medication administration, assistance with dressing and grooming, bathing, gastronomy (G-tube) flush, vital signs, and behavior management. R2's Resident Notes - Nurse dated August 19, 2024, indicated R2 was transferred to Fairview Southdale ER and was discharged from hospital August 29, 2024. R2's 90-day (Nursing) assessment dated November 11, 2024, and February 19, 2025, were completed by licensed practical nurse (LPN)-D. R2's record lacked reassessment completed by a registered nurse (RN) after a hospitalization in August 2024. On March 26, 2025, at 1:30 p.m., clinical nurse supervisor (CNS)-A stated the license's process required the RN to complete the initial assessments and change of condition assessments, while the LPN was responsible reassessments or 90 days assessments. CNS-A acknowledged R2 had a change of condition on August 29, 2024, and the last two nursing assessments dated November 11, 2024, and February 19, 2025, were completed by a LPN. The licensee's IAL And On-Going Nursing Assessment Of Residents policy dated August 1, 2021, indicated "Nursing assessments are completed by a registered nurse based upon the required assessment schedule and as needed based upon resident condition."	01620		

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01620	Continued From page 45 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01650 SS=D	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced	01650		

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01650	Continued From page 46 by: Based on interview and record review, the licensee failed to ensure the current service plan included a signature or other authentication by the resident or the resident's representative to document agreement on the services to be provided 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, 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 resident are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R3 was admitted February 27, 2025, with diagnoses that included but were not limited to diabetes. R3's unsigned Service Plan with effective date March 12, 2025, indicated R3 received services which included medication administration, blood sugar checks, assistance with bathing, dressing, transfer, and toileting. R3's record lacked a current service plan with signature or authentication by the resident or resident's representative with all current services provide by licensee. On March 26, 2025, at 1:30 p.m., clinical nurse supervisor (CNS)-A stated R3's service plan was not signed by the resident or resident's representative. CNS-A stated that at the time R3 was admitted they were going through staffing	01650		

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01650	Continued From page 47 change and service plan was oversite. The licensee's Contents Of Service Plans policy dated August 1, 2021, indicated "Service plans and any revisions to services plans will have a signature or other authentication by the facility and by the resident." No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01650		
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel;	01730		

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01730	Continued From page 48 (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 interview, the licensee failed to develop an individualized medication management plan with the required content for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2's Service Plan dated September 23, 2022, indicated R2 received assistance with medication administration, assistance with dressing and	01730		

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01730	Continued From page 49 grooming, bathing, gastronomy (G-tube) flush, vital signs, and behavior management. R2's 90-day (Nursing) assessment dated November 11, 2024, and February 19, 2025, noted R1 received medication management services. R2's record lacked a medication management plan to include required content noted below: - a statement describing the medication management services that will be provided; - identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; - identification of medication management tasks that may be delegated to unlicensed personnel; and - the medication management record must be current and updated when there are any changes. On March 26, 2025, at 1:30 p.m., clinical nurse supervisor (CNS)-A stated R2's record was missing evidence of a medication management plan to include the above noted content. CNS-A stated she would have to retrain the licensed practical nurse (LPN) to make sure the medication management plan to include all the required content. The licensee's Medication, Treatment And Therapy Reminders policy dated August 01, 2021 indicated "Prior to providing any medication, treatment and therapy reminders, a RN will conduct a nursing assessment of a resident ' s functional status and need for medication, treatment and therapy reminders or other medication, treatment and therapy management services and develop an individualized medication management plan an/or treatment	01730		

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01730	Continued From page 50 and therapy individualized plan for the resident based on the resident ' s needs and preferences." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01770 SS=F	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 two of two residents (R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on March 24, 2025, at 11:00 a.m., clinical nurse supervisor	01770		

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01770	Continued From page 51 (CNS)-A stated the licensee provided medication management services which included medication setup by the licensed practical nurse (LPN) for the residents. On March 25, 2025, from 8:00 a.m. to 10:00 a.m., the surveyor observed unlicensed personnel (ULP)-B administer medications to R2 and R3 from respective pill planner seven-day dosage boxes. ULP-B stated she finds the correct resident's name and time on the medication pill planner seven-day dosage boxes and administers those medications to the residents. ULP-B documented medication administration in the medication administration record (MAR). R2 and R3's records lacked medication set-up documentation to include dates of medication setup, names of medications, quantity of doses, times to be administered, routes of administration, and name of person completing medication setup. On March 26, 2025, at 1:30 p.m., CNS-A confirmed the licensee provided weekly medication set-up services for all residents. CNS-A acknowledged R2 and R3's records were missing documentation of medication setup including all the required content. CNS-A stated she would have to retrain the LPN to make sure documentation of medication setup included all the required content. The licensee's Medication, Treatment And Therapy Reminders policy dated August 1, 2021, indicated the nurse who sets up the medications in the dosage box will monitor the medication reminder documentation and compliance and will initial that this has been done. The medication regimen will also be updated and reviewed at the	01770		

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01770	Continued From page 52 same time of medication set up. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01770		
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide documentation in the resident's record regarding the disposition of medication to include quantity and names of staff and other individuals involved in the disposition of medications for one of one discharged resident	01910		

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01910	Continued From page 53 (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: R1 started services on November 10, 2022. R1's Service Plan dated November 25, 2022, indicated R1 received medication administration services daily. R1's Discharge Care Plan indicated R1 discharged from the facility on December 9, 2024. R1's record lacked documentation of R1's disposition of medications to include name of the medication, strength, prescription number if applicable, quantity, to whom the medications were given, date of disposition, and the names of the staff and other individuals involved in the disposition. On March 26, 2025, at 1:30 p.m., clinical nurse supervisor (CNS)-A stated the disposition of medications was not documented for discharged resident R1. CNS-A stated they have processes in place to document in the resident's record the disposition of the medication, but was oversite. No further information was provided.	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32015	A. BUILDING: _____ B. WING _____	03/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKINSON'S SPECIALTY CARE	6804 DOVRE DRIVE EDINA MN 55436 EDINA, MN 55436

(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
01910	Continued From page 54 TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
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	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32015	A. BUILDING: _____ B. WING _____	03/28/2025

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01940	Continued From page 55 by: Based on observation, interview, and record review, the licensee failed to develop a treatment management plan to include all required content for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R3 was admitted February 27, 2025, with diagnoses that included but were not limited to diabetes. R3's unsigned Service Plan with effective date March 12, 2025, indicated R3 received services which included medication administration, blood sugar checks, assistance with bathing, dressing, transfer, and toileting. R3's record lacked a treatment and therapy management plan to include: -documentation of specific resident instructions relating to the treatment or therapy administration; and -procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and -any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32015	A. BUILDING: _____ B. WING _____	03/28/2025

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01940	Continued From page 56 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. On March 26, 2025, at 1:30 p.m., clinical nurse supervisor (CNS)-A stated a treatment management plan with the required content had not been developed for R3. CNS-A stated that at the time R3 was admitted they were in the process of transitioning to new a licensed practical nurse (LPN) and the missing treatment plan was oversite. The licensee's Medication, Treatment And Therapy Reminders policy dated August 1, 2021 indicated "Prior to providing any medication, treatment and therapy reminders, a RN will conduct a nursing assessment of a resident ' s functional status and need for medication, treatment and therapy reminders or other medication, treatment and therapy management services and develop an individualized medication management plan an/or treatment and therapy individualized plan for the resident based on the resident ' s needs and preferences." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
02310 SS=G	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	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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02310	Continued From page 57 resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care standards, medical or nursing standards for one of one resident (R2) with a consumer bedrail. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at 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 March 24, 2025, at 12:30 p.m., the surveyor observed R2's bed had a white M-shaped bedrail, which was not attached to R2's bed. The bedrail was in between the mattress and bed frame. When the mattress was lifted, the surveyor observed the bedrail was not secured to the bed frame. Clinical nurse supervisor (CNS)-A grasped the bedrail and noted the bedrail was not secured to the bed or bed frame and moved when pulled and pushed on. R2 was in his room sitting in a power wheelchair. R2 was non-verbal, but R2 communicated in writing. R2 stated he installed the bedrail and R2 stated he used bedrail for positioning. R2 did not remember if education about the potential risks associate with bedrails, including risk of entrapment, was provided by the	02310	During the course of the survey, the licensee took action to mitigate the imminent risk. Noncompliance remained and the scope and level remain unchanged.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32015	A. BUILDING: _____ B. WING _____	03/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKINSON'S SPECIALTY CARE	6804 DOVRE DRIVE EDINA MN 55436 EDINA, MN 55436

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02310	Continued From page 58 licensee. R2's diagnoses included but were not limited to Parkinson's disease. R2's Service Plan dated September 23, 2022, indicated R2 received assistance with medication administration, assistance with dressing and grooming, bathing, gastrostomy (G-tube) flush, vital signs, and behavior management. R2's 90-day (Nursing) assessment dated February 19, 2025, completed by licensed practical nurse (LPN)-D, indicated R2 had bedrails in use, and a half bedrail was used by R2 for positioning. The assessment indicated R2 had been increasingly weak. R2's Individual Abuse Prevention Plan dated February 19, 2025, indicated bedrails were in use, include a description of the half rail used by R2 for positioning. R2's record lacked: -documentation the portable bedrails were used, installed, and maintained according to the manufacturer's guidelines; -documentation the Consumer Product Safety Commission (CPSC) was reviewed for recalls; and -and documentation the risk vs. benefits were discussed with the resident/responsible party. On March 24, 2025, at 2:30 p.m. CNS-A acknowledged R2 had a change of condition since their admission in 2022, and initially R2 was ambulatory and installed the bedrail. CNS-A stated R2's 90-day (Nursing) assessment dated February 19, 2025, completed by LPN-D, was missing evidence of installation and use of the	02310		

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	32015	A. BUILDING: _____ B. WING _____	03/28/2025

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02310	Continued From page 59 device according to manufacturer's guidelines, education to the R2 about the potential risks associate with siderails. In addition, CNS-A confirmed they had not verified the bedrail had not been recalled by the CPSC. The licensee's Devices and Bedrail Assessment policy dated August 1, 2021, indicated due to the risk of injury related to the use of physical devices, such devices will only be used after an assessment has been completed to determine the risks and benefits of this use. The resident/responsible party will be educated regarding the risks and benefits of physical devices. Physical devices will be reviewed for safety and used according to manufacturer's recommendations. Continued use of physical devices will be assessed at least every 90 days or with significant change to determine if the device is still needed to enhance the resident's safety and/or bed mobility. If the physical device restricts a resident's freedom of movement, it constitutes a restraint, and our facilities are restraint free. Physical devices that do not restrict the resident's freedom of movement and are used to assist the resident/client in bed mobility are not restraints. Physical devices include, but are not limited to, side rails (half or full); grab bars, halo bars, positioning poles. Grab bars that are either placed/attached or strapped between the mattress and box spring or bed frame are not allowed in our building. If the facility staff learn of a device like this on a bed it will be removed and alternatives will be discussed with the resident/responsible party. If a resident needs a device to assist with bed mobility the preferred device is a Halo. This device can be safely placed on a residential bed. The Food and Drug Administration (FDA), A	02310		

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02310	Continued From page 60 Guide to Bed Safety revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." The Drive M-Rail (model 1222P) Installation Instructions dated 2014, indicated entrapment between an assisted bedside handrail device and a mattress can be serious and potentially life-threatening and entrapment can occur when there is a gap between the side of the mattress and the assistive handrail. The instructions further indicated the bedrail installation included long webbing straps to attach the bedrail securely to the bedframe and prevent the gap between the mattress and assistive device. The Minnesota Department of Health Assisted Living Resources and Frequently Asked Questions (FAQs) dated December 13, 2024, indicated documentation about a resident's bedrails includes, but is not limited to: -Purpose and intention of the bedrail; -Condition and description (i.e., an area large enough for a resident to become entrapped) of the bedrail; -The resident's bedrail use/need assessment; -Risk vs. benefits discussion (individualized to each resident's risks); -The resident's preferences; -Installation and use according to manufacturer's	02310		

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02310	Continued From page 61 guidelines; -Physical inspection of bedrail and mattress for areas of entrapment, stability, and correct installation; -Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements; and -Documentation of review of the CPSC website regularly for updates on recalled portable bedrails. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	02310		

Minnesota Department of Health

625 Robert Street North
St Paul
651-201-4500

Type: Full
Date: *03/24/25*
Time: 11:12:28
Report: 7994251081

Food and Beverage Establishment Inspection Report

Location:

Parkinson's Specialty Care
6804 Dovre Drive
Edina, MN55436
Hennepin County, 27

Establishment Info:

ID #: 0040159
Risk:
Announced Inspection: No

License Categories:

Expires on: 12/31/22

Operator:

Phone #:
ID #:

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

The following orders were issued during this inspection.

3-500B Microbial Control: hot and cold holding

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

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

ALL ITEMS IN LOWER HALF OF FRIDGE FOUND ABOVE 41 F. SPOKE WITH STAFF ABOUT ADJUSTING FRIDGE.

Comply By: 03/24/25

4-300 Equipment Numbers and Capacities

4-302.13A ***** Priority 2 *****

MN Rule 4626.0710A Provide a readily accessible temperature measuring device for measuring the washing and sanitizing temperatures in manual warewashing operations.

NO TEST STRIPS FOUND ON SITE FOR TESTING THE DISHWASHER TEMPERATURES. PROVIDED A TEST STRIP AND REQUIRED FACILITY TO EMAIL PICTURE TO INSPECTOR.

Comply By: 03/24/25

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.

LEFT OVER FOODS FOUND IN FRIDGE IN ZIP LOCK BAG. ONLY FOOD THAT IS PREPARED AND SERVED THE SAME DAY MAY BE SERVED IN THE FACILITY.

Comply By: 03/24/25

8-500A Embargo/Condemnation

8-501.03MN

MN Rule 4626.1810 The following items are condemned and shall be removed from the establishment immediately:

DISCARD ALL TCS FOODS ON LOWER HALF OF FRIDGE. ADJUST FRIDGE BEFORE RESTOCKING.

Comply By: 03/24/25

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

INSPECTION CONDUCTED IN THE PRESENCE OF HRD STAFF AND FINDINGS SHARED AT THE END OF INSPECTION.

WILL EMAIL SUPPORTING DOCUMENTS AND LINKS TO HRD STAFF AT THE END OF THE DAY.

KITCHEN IS RESIDENTIAL AND FOOD IS PREPARED FOR SAME DAY SERVICE.

FLOOR IS WOOD LAMINATE, CABINETS ARE WOOD WITH HALLOWED ENCLOSED BASES, LAMINATE COUNTER TOPS AND POPCORN TEXTURED CEILING. ALL ARE FOUND TO BE IN GOOD CONDITION AND WILL BE MONITORED AT FUTURE INSPECTIONS. IF AT ANY TIME THERE IS FOUND TO BE A RISK OF CONTAMINATION OR CONCERN THE PHYSICAL FACILITIES WILL BE REQUIRED TO BE BROUGHT UP TO CODE.

TEMPERATURES:
MILK 41
HAM 45
CHEESE 44
POTATOES 43

SANITIZERS:
FACILITY WILL EMAIL PICTURE OF TEST STRIP

Type: Full
Date: *03/24/25*
Time: 11:12:28
Report: 7994251081
Parkinson's Specialty Care

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 7994251081 of 03/24/25.

Certified Food Protection Manager: Marcella Marshall

Certification Number: 116443 Expires: 04/18/26

Inspection report reviewed with person in charge and emailed.

Signed: _____
Marilyn Egge

Signed: Crystal Elva
Crystal Elva
Public Health Sanitarian 3
St Paul
651-201-3981
Crystal.Elva@state.mn.us