Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

February 5, 2025

Licensee
Evergreen Assisted Living Care Homes Inc.
6629 Xerxes Avenue South
Minneapolis, MN 55423

RE: Project Number(s) SL40105015

Dear Licensee:

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

The Minnesota Department of Health completed an initial survey on December 12, 2024, for the purpose assessing compliance with state licensing statutes. At the time of the survey, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G.

The Department of Health concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

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

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

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

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

0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00

The total amount you are assessed is $500.00. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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 MDH 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.

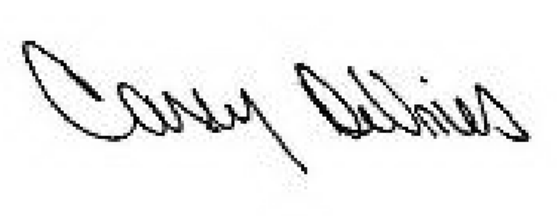
To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration or a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms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



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

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40105	A. BUILDING: _____ B. WING _____	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVERGREEN ASSISTED LIVING CARE HOMES	6629 XERXES AVE SOUTH MINNEAPOLIS, MN 55423

(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 ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL40105015-0 On December 9, 2024, through December 12, 2024, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were three residents; three receiving services under the Provisional Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living 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.	
0 180 SS=F	144G.16 Subd. 2 Initial survey (a) During the provisional license period, the commissioner shall survey the provisional licensee after the commissioner is notified or has evidence that the provisional licensee is providing	0 180		

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0 180	Continued From page 1 assisted living services to at least one resident. (b) Within two days of beginning to provide assisted living services, the provisional licensee must provide notice to the commissioner that it is providing assisted living services by sending an e-mail to the e-mail address provided by the commissioner. (c) If the provisional licensee does not provide services during the provisional license period, the provisional license shall expire at the end of the period and the applicant must reapply. (d) If the provisional licensee notifies the commissioner that the licensee is providing assisted living services within 45 calendar days prior to expiration of the provisional license, the commissioner may extend the provisional license for up to 60 calendar days in order to allow the commissioner to complete the on-site survey required under this section and follow-up survey visits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to notify the Minnesota Department of Health (MDH) within two days of starting services. This had the potential to affect all residents residing at the assisted living facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	0 180		

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0 180	Continued From page 2 The licensee was issued their Provisional Assisted Living license on December 4, 2023. R5 was admitted and began receiving assisted living services on January 4, 2024. The licensee notified the Minnesota Department of Health (MDH) of providing services January 15, 2024. The licensee failed to provide notice to MDH within two (2) days when licensee first started providing assisted living services. On December 11, 2024, at approximately 1:00 p.m., during a phone interview, agent (A)-A stated they think they had forgotten to send the notification within the required timeframe. No further information provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 180		
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 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	0 480		

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0 480	Continued From page 3 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 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.	0 480		

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0 480	Continued From page 4 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated December 9, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 485 SS=C	144G.41 Subdivision 1.a (a) Minimum requirements; required food services All assisted living facilities must offer to provide or make available at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal	0 485		

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0 485	Continued From page 5 fresh fruit and fresh vegetables. The menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes. The facility must not require a resident to include and pay for meals in the resident's contract. 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 require any resident to include and pay for meals as a part of their assisted living package fee. This had the potential to affect all residents of the facility. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On December 10, 2024, at 11:19 a.m., agent (A)-A provided a blank copy of the licensee's contract. A-A stated the same contract was used by all residents within the facility and there were no additional documents or addendums to the current contract. A-A stated upon admission, residents sign the contract and then receive copies of the facility's Uniform Disclosure of Amenities and Services (UDALSA) and assisted	0 485		

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0 485	Continued From page 6 living bill of rights. The Occupant Agreement included the following language: On page 2, in the section titled Included services, A. Direct care services, 1. Meals and Snacks: 3 nutritionally well-balanced meals per day are included in your basic core services rate. On December 11, 2024, at approximately 11:30 a.m., agent (A)-A stated they were not aware the licensee's contract could not contain this information. Additionally, A-A stated there were no additional documents provided to residents to deduct the cost of meals from the billed monthly rate. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced	0 510		

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0 510	Continued From page 7 by: Based on observation, interview, and record review, the licensee failed to establish and maintain an effective infection control program that complied with accepted health care, medical and nursing standards for infection control related to gloving and hand hygiene for one of one employee (unlicensed personnel (ULP)-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-E was hired June 20, 2024, to provide assisted living services. On December 10, 2024, at 7:31 a.m., during continuous observation, the surveyor observed ULP-E log into their computer to prepare for medications administration. ULP-E washed their hands at the kitchen sink. After completing hand hygiene, ULP-E obtained a clean pair of gloves, put the opening of the gloves to their mouth, blew air into their gloves, and put on the gloves. At 7:41 a.m., ULP-E administered medications to R2. At 7:43 a.m., ULP-E returned to the medication cabinet to document administration and prepare medications for R4. At 7:44 a.m., ULP-E changed gloves without completing hand hygiene. ULP-E administered R4's medications at 7:53 a.m., and then returned to the medication cabinet to document administration. After completing documentation, while wearing the	0 510		

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0 510	Continued From page 8 same gloves, ULP-E left the computer at 8:00 a.m., to check on R3. At 8:02 a.m., while wearing the same gloves, ULP-E assisted R3 into the bathroom. At 8:05 a.m., ULP-E removed their dirty gloves and then completed hand hygiene at the kitchen sink. At 8:06 a.m., ULP-E obtained a clean set of gloves and again blew air into their gloves prior to putting on the gloves. At 8:07 a.m., ULP-E obtained a blood glucose on R3. At 8:14 a.m., without completing hand hygiene or changing gloves, ULP-E returned to the medication cabinet to prepare morning medications for R3. At 8:19 a.m., the surveyor observed ULP-E administer medications to R3 and then return to the medication cabinet for documentation of medication administration. At 8:22 a.m., the surveyor observed ULP-E remove gloves. The surveyor did not observe ULP-E complete hand hygiene after disposing of the gloves. On December 11, 2024, at 11:04 a.m., ULP-E stated they were trained to complete hand hygiene in between all glove changes. ULP-E stated they were not trained to blow air into gloves prior to administration and it was something they had seen doctors do in the past and did not think it was a potential risk for infection. On December 11, 2024, at 3:01 p.m., clinical nurse supervisor (CNS)-B stated staff were trained to complete hand hygiene before, after, and in between all glove changes. CNS-B stated that if staff were observed blowing air into their gloves prior to putting them on, they would be expected to start over, and wash their hands. The licensee Infection Control Policy, dated December 2023, indicated every employee must	0 510		

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0 510	Continued From page 9 ensure that they are aware of and understand the proper selection and usage of personal protective equipment. The CDC's Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings, dated April 12, 2024, subsection 5a. Hand Hygiene References and resources indicated the following: 1. Require healthcare personnel to perform hand hygiene in accordance with Centers for Disease Control and Prevention (CDC) recommendations. 2. Use an alcohol-based hand rub or wash with soap and water for the following clinical indications: a. Immediately before touching a patient b. Before performing an aseptic task (e.g., placing an indwelling device) or handling invasive medical devices c. Before moving from work on a soiled body site to a clean body site on the same patient d. After touching a patient or the patient's immediate environment e. After contact with blood, body fluids or contaminated surfaces f. Immediately after glove removal No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 660 SS=D	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	0 660		

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0 660	Continued From page 10 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 maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), which included a two-step tuberculin skin test (TST) or other evidence of TB screening such as a blood test for one of two employees (clinical nurse supervisor (CNS)-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, 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: The licensee's facility TB risk assessment dated December 1, 2024, indicated the facility had a low risk.	0 660		

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0 660	Continued From page 11 CNS-B was hired August 7, 2024, to provide assisted living services. CNS-B's employee record lacked documentation indicating completion of a two-step tuberculosis screening. On December 11, 2024, at 3:00 p.m., during a phone interview, CNS-B stated they thought a TB test was provided to the facility upon hire. On December 12, 2024, at 8:25 a.m., agent (A)-A stated they did not have a TB test on file for CNS-B. The facility's undated Tuberculosis Screening Policy indicated all employees must complete baseline tuberculosis screening. The CDC Tuberculosis Screening, Testing, and Treatment of U.S. Health Care Personnel dated May 17, 2019, indicated all health personnel should have a baseline screening and an individual risk assessment, which is necessary for interpreting any test result. 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 (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses	0 680		

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0 680	Continued From page 12 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 maintain a written emergency preparedness plan (EPP) with all the required content as defined in Appendix Z. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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).	0 680		

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0 680	Continued From page 13 The findings include: On December 9, 2024, at 1:44 p.m., the surveyor requested the licensee's EPP for review. Vice president (V)-D stated they were responsible for the development of the EPP, and the licensee had the document stored in a digital format in the licensee's secure Google drive. V-D stated the document had not yet been established in paper format, or in a way that would be easily accessible to the public. The licensee's Emergency Action Plan policy dated April 2024, indicated the purpose of the emergency action plan was to coordinate and streamline employee and company procedures in the event of an emergency in the workplace. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 700 SS=F	144G.43 Subdivision 1 Resident record (b) Resident records, whether written or electronic, must be protected against loss, tampering, or unauthorized disclosure in compliance with chapter 13 and other applicable relevant federal and state laws. The facility shall establish and implement written procedures to control use, storage, and security of resident records and establish criteria for release of resident information. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure personal	0 700		

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0 700	Continued From page 14 health and medical information was kept private for three of three residents (R2, R3, R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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 December 10, 2024, during continuous observation from 7:31 a.m., to 8:22 a.m., the surveyor observed unlicensed personnel (ULP)-E administer medications to all residents residing within the facility. At 7:31 a.m., the surveyor observed ULP-E unlock the licensee's medication cabinet and prepare medications for R2 using the licensee's electronic medication administration record (EMAR). After preparing medications, at 7:34 a.m., ULP-E left the computer unlocked and unattended with the licensee's EMAR open and visible while administering medications to R2. From 7:44 a.m., to 7:53 a.m., ULP-E left the computer unlocked and unattended with the licensee's EMAR open and visible while administering medications to R4. From 8:00 a.m., to 8:05 a.m., ULP-E left their computer unlocked and unattended with the licensee's EMAR open and visible while assisting R3 in the bathroom. On December 11, 2024, at 10:48 a.m., ULP-E stated they were trained to ensure resident records were secured. ULP-E stated it was their first time being observed by a surveyor and they had become nervous.	0 700		

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0 700	Continued From page 15 On December 11, 2024, at 11:27 a.m., agent (A)-A stated staff were trained to close the computer when leaving it unattended. A-A stated the licensee had just switched from using tablets to using laptops and it was likely staff had not gotten used to the habit of securing the laptop screens when leaving the device unattended. On December 11, 2024, at 3:14 p.m., clinical nurse supervisor (CNS)-B stated staff were expected to secure their computers when leaving the computer unattended. The licensee's Medical Documents Policy and Procedure dated February 2024 indicated staff will guarantee the confidentiality of individual patient information. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 700		
0 780 SS=F	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; (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	0 780		

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0 780	Continued From page 16 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 provide smoke alarms that were interconnected so that the actuation of one alarm caused all alarms in the dwelling unit to actuate. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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 December 9, 2024, from 12:00 p.m. to 1:00 p.m., the surveyor toured the facility with vice president (V)-D. Survey staff asked V-D to initiate a test of the smoke alarms throughout the facility. Upon testing, it was found that the smoke alarms in the facility were not interconnected.	0 780		

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0 780	Continued From page 17 Upon V-D testing the smoke alarms it was discovered that the smoke alarm located in the first-floor common hallway between resident rooms 1 and 2 was interconnected with only the basement smoke alarm located in the common hallway outside resident room 3. When the smoke alarm located in the first-floor dining room was tested it was discovered that it was only interconnected with the smoke alarms in first-floor resident rooms 1 and 2. The second-floor smoke alarm was not interconnected with any of the other smoke alarms installed in the facility. The smoke alarm located in the resident room 3 was not interconnected with any of the other smoke alarms installed in the facility. All dwelling units required to have multiple smoke alarms are required to have interconnected alarms so activation of one alarm activates all alarms within the dwelling unit. These deficient conditions were verified by V-D accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping	0 810		

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0 810	Continued From page 18 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 interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required training and drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 810		

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0 810	Continued From page 19 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 December 9, 2024, agent (A)-A and vice president (V)-D provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN: The licensee's FSEP, titled "Fire Emergency Policy", revised 4/2024, failed to include the following: The FSEP included standard procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate) but the plan was designed for a building with life safety systems such as fire doors and smoke compartments. The policy included instructions to avoid using elevators in an emergency. No elevator is present in the facility. The policy had not been updated to provide complete actions for employees to take in the event of a fire or similar emergency at the licensed facility which did not have life safety systems or a fire-resistant construction type. The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic	0 810		

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0 810	Continued From page 20 evacuation procedures that residents should follow in case of a fire or similar emergency. The FSEP included standard resident evacuation procedures but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan included instructions to evacuate residents but did not include any procedures for assisting residents during evacuation nor did it include instructions for staff to follow in case of relocation. On December 9, 2024, at 2:10 p.m., A-A stated they understood the areas of their policy that were incomplete and would work on bringing them into compliance. TRAINING: The licensee failed to provide evacuation training to residents at least once per year. A-A lacked documentation showing any training was offered or training was scheduled for a future date for residents on the fire safety and evacuation plan. The licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. The licensee lacked documentation showing any training was completed or scheduled for a future date for staff. DRILLS: The licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month. Record review of licensee's evacuation drill log, titled "Fire Drill Log", indicated evacuation drills were conducted in January, April, July, October, November, and December for first shift. The fire	0 810		

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0 810	Continued From page 21 drill log also indicated one drill was conducted on second shift in April. No record of fire drills being conducted on third shift. No other documentation was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 920 SS=C	144G.50 Subd. 2 (c) Contract information (c) The contract must include: (1) a disclosure of the category of assisted living facility license held by the facility and, if the facility is not an assisted living facility with dementia care, a disclosure that it does not hold an assisted living facility with dementia care license; (2) a description of all the terms and conditions of the contract, including a description of and any limitations to the housing or assisted living services to be provided for the contracted amount; (3) a delineation of the cost and nature of any other services to be provided for an additional fee; (4) a delineation and description of any additional fees the resident may be required to pay if the resident's condition changes during the term of the contract; (5) a delineation of the grounds under which the resident may be transferred or have housing or services terminated or be subject to an emergency relocation; (6) billing and payment procedures and requirements; and (7) disclosure of the facility's ability to provide specialized diets. This MN Requirement is not met as evidenced by:	0 920		

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0 920	Continued From page 22 Based on interview and record review, the licensee failed to execute a written contract with the required content for all residents residing within the facility. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On December 10, 2024, at 11:19 a.m., agent (A)-A provided a blank copy of the licensee's contract. A-A stated the same contract was used by all residents within the facility and there were no additional documents or addendums to the current contract. - The provided contract lacked a disclosure of the category of assisted living facility license held by the facility and, if the facility is not an assisted living facility with dementia care, a disclosure that it does not hold an assisted living facility with dementia care license. On December 11, 2024, at approximately 11:30 a.m., A-A stated they were not aware the licensee's contract was required to contain the above information. Additionally, A-A stated the licensee had recently purchased a new policy manual and contract from a provider organization but had not been able to implement it yet. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	0 920		

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0 920	Continued From page 23 (21) days	0 920		
0 940 SS=C	144G.50 Subd. 2 (e; 5-7) Contract information (5) a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including: (i) whether the facility is enrolled with the commissioner of human services to provide customized living services under medical assistance waivers; (ii) whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b); (iii) whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided; (iv) whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required; (v) a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent; (vi) a statement that residents may be eligible for assistance with rent through the housing support program; and (vii) a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program; (6) the contact information to obtain long-term care consulting services under section 256B.0911; and (7) the toll-free phone number for the Minnesota	0 940		

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0 940	Continued From page 24 Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for all residents residing within the facility. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On December 10, 2024, at 11:19 a.m., agent (A)-A provided a blank copy of the licensee's contract. A-A stated the same contract was used by all residents within the facility and there were no additional documents or addendums to the current contract. - The provided contract lacked a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including: - whether the facility is enrolled with the commissioner of human services to provide customized living services under medical assistance waivers; - whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b); - whether there is a limit on the number of people residing at the facility who can receive	0 940		

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0 940	Continued From page 25 customized living services or participate in the housing support program at any point in time. If so, the limit must be provided; - whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required; - a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent; - a statement that residents may be eligible for assistance with rent through the housing support program; and - a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program. On December 11, 2024, at approximately 11:30 a.m., A-A stated they were not aware the licensee's contract was required to contain the above information. Additionally, A-A stated the licensee had recently purchased a new policy manual and contract from a provider organization but had not been able to implement it yet. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 940		
0 950 SS=C	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim	0 950		

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0 950	Continued From page 26 notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to offer the resident the opportunity to identify a designated representative in writing with the required statutory language. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected	0 950		

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0 950	Continued From page 27 or has the potential to affect a large portion or all the residents). The findings include: On December 10, 2024, at 11:19 a.m., agent (A)-A provided a blank copy of the licensee's contract. A-A stated the same contract was used by all residents within the facility and there were no additional documents or addendums to the current contract. - The provided contract lacked a document which provided the opportunity to designate a representative and the verbatim "right to designate a representative for certain purposes" notice. On December 11, 2024, at approximately 11:30 a.m., A-A stated they were not aware the licensee's contract was required to contain the above information. Additionally, A-A stated the licensee had recently purchased a new policy manual and contract from a provider organization but had not been able to implement it yet. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 950		
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	0 970		

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0 970	Continued From page 28 lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the facility's liability for health, safety, or personal property of a resident. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive 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 December 10, 2024, at 11:19 a.m., agent (A)-A provided a blank copy of the licensee's contract. A-A stated the same contract was used by all residents within the facility and there were no additional documents or addendums to the current contract. The Occupant Agreement included the following language: - Page 9, in the section titled Facility Property, "In addition, you shall reimburse the facility for any loss or damage to the facility's real or personal property outside of your room/unit caused either intentionally or negligently by you or by persons on the premises with your consent. The facility is not liable for any lost or damaged personal property owned by you or persons on	0 970		

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0 970	Continued From page 29 the premises visiting you." - Page 10, in the section titled Residents Property, "The facility is not responsible for loss of any property belonging to you due to theft or any other cause. You are responsible for purchasing and maintaining insurance to cover damage to or the loss of your property." On December 11, 2024, at approximately 11:30 a.m., A-A stated they were not aware the licensee's contract could not contain this information. Additionally, A-A stated the licensee had recently purchased a new policy manual and contract from a provider organization but had not been able to implement it yet. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
01530 SS=D	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another	01530		

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01530	Continued From page 30 employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure staff received eight hours of initial dementia care training within the first 120 working hours of employment for supervisors of direct care staff as required for one of three employees (clinical nurse supervisor (CNS)-B) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: CNS-B was hired August 7, 2024, to provide assisted living services as well as clinical oversight and supervision to the unlicensed personnel. CNS-B's training transcript included dementia	01530		

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01530	Continued From page 31 training courses completed between September 12, 2024, and September 15, 2024, to include a total of six and a one quarter hours (6.25) hours of dementia training. On December 11, 2024, at 3:04 p.m., CNS-B stated they had worked over 160 hours since the time of their hire and had only completed 6.25 hours of the required eight hours of initial dementia training, and were not aware of this requirement. The licensee's Dementia Training Policy dated April 2024 indicated staff will undergo at least 4 hours of dementia care training upon hire and at least 2 hours annually. The licensee's policy did not reflect the minimum required by state statute for supervisors of direct care staff. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
01610 SS=F	144G.70 Subd. 2 (a-b) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and	01610		

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01610	Continued From page 32 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 interview and record review, the licensee failed to ensure the registered nurse (RN) completed an initial comprehensive nursing assessment prior to the execution of the assisted living contract/providing services for two of three residents (R3, R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: R3 R3 was admitted to the licensee on December 6, 2024, to receive assisted living services. R3's primary diagnosis was dementia. R3's Service Plan - Modification dated December 10, 2024, indicated R3 recieved asssistance with activities, ambulation, appointment assistance, bathing assistance, bed making, assistance with dressing, diabetic equipment care, escort assistance, assistance with grooming,	01610		

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01610	Continued From page 33 incontinence care, assistance with laundry, behavior management, meal assistance, medication administration, nail care, and assistance with toileting. R3's record lacked an initial assessment at the time of the start of survey, December 9, 2024, indicating that three days had passed since admission with no admission assessment. On December 9, 2024, at approximately 10:30 a.m., during the entrance conference clinical nurse supervisor (CNS)-B stated nurses were expected to come in over weekends to complete admission or change of condition assessments. On December 9, 2024, at 1:53 p.m., CNS-B stated they were unable to make it in over the weekend to complete an admission assessment and the licensee's backup nurse was also unable to make it in to complete an admission assessment on R2. R4 R4 was admitted to the licensee on July 28, 2024, to receive assisted living services. R4's diagnosis included malignant neoplasm of colon, chronic obstructive pulmonary disease, and peripheral vascular disease. R4's Service Plan - Modification dated December 10, 2024, indicated R4 received services including ambulation, appointment reminders, bathing assistance, deep room cleaning, dressing assistance, escort assistance, grooming assistance, incontinence care, laundry assistance, behavior management, assistance with meals, medication administration, vital signs, safety checks, and toileting assistance.	01610		

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01610	Continued From page 34 R4's record contained an admission assessment dated August 7, 2024, indicating that 10 days had lapsed since admission date and admission assessment. On December 11, 2024, at approximately 11:30 a.m., agent (A)-A stated the licensee was in-between nurses at the time of R4's admission. On December 11, 2024, at approximately 3:00 p.m., CNS-B stated R4 was admitted prior to them being hired by the licensee. The licensee's undated Service Policy and Procedure document indicated 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. The licensee's undated Initial Assessments and Continuing Assessments policy indicated the licensee must not admit or retain a resident unless it can provide sufficient care and supervision to meet the resident's needs, based on the resident's known physical, mental, cognitive, or behavioral condition. Additionally, the policy indicated the licensee must be able to conduct a nursing assessment on a holiday or on a weekend for a resident who is ready to be discharged from the hospital and return to the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01610		

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01620	Continued From page 35	01620		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed a reassessment not to exceed 90 days for one of three residents (R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and	01620		

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01620	Continued From page 36 was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R4 was admitted to the licensee on July 28, 2024, and began receiving assisted living services. R4's diagnoses included Alzheimer's disease, encephalopathy, depression, anxiety disorder, low back pain, fibromyalgia, and muscle weakness. R4's Service Plan - Modification dated December 10, 2024, indicated R4 received services including ambulation, appointment reminders, bathing assistance, deep room cleaning, dressing assistance, escort assistance, grooming assistance, incontinence care, laundry assistance, behavior management, assistance with meals, medication administration, vital signs, safety checks, and toileting assistance. R4's record included a 14-day assessment completed on August 27, 2024, and a 90-day assessment dated December 9, 2024, which occurred after the start of survey, and indicated that 104 days had lapsed since the last assessment. On December 11, 2024, at 3:06 p.m., clinical nurse supervisor (CNS)-B stated they were aware there was a lapse in assessments, and since they did not start until August of 2024, they had attempted to see all residents as soon as possible to get everyone back on schedule. The licensee's undated Initial Assessment and	01620		

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01620	Continued From page 37 Continuing Assessments policy indicated assessments were to take place on pre-admission, admission, 14 days after admission, and then every 90 days from the admission assessment date. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01650 SS=F	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	01650		

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01650	Continued From page 38 consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the service plan included all required content for three of three residents (R2, R3, R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R2 R2 admitted to the licensee on June 4, 2024, to receive assisted living services. R2's Service Plan - Modification signed December 10, 2024, indicated R2 received assistance with ambulation, bathing assistance, bedmaking, deep room cleaning, assistance with dressing in the morning and evening, drinking assistance, glasses care, grooming, housekeeping, incontinence care, laundry, behavior management, positioning and repositioning, vital signs, safety checks, assistance with transfers, and wheelchair use. R3 R3 was admitted to the licensee on December 6,	01650		

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	40105	A. BUILDING: _____ B. WING _____	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVERGREEN ASSISTED LIVING CARE HOMES	6629 XERXES AVE SOUTH MINNEAPOLIS, MN 55423

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01650	Continued From page 39 2024, to receive assisted living services. R3's unsigned Service Plan - Modification document indicated R3 received assistance with ambulation, appointment reminders, beathing assistance, bed making, deep room cleaning, dressing assistance in the morning and evening, drinking assistance, care of diabetic equipment, assistance with escorts, grooming, incontinence care, laundry, behavior management, meal assistance, medication administration, nail care, vital signs, and toileting assistance. R4 R4 was admitted to the licensee on July 28, 2024, to receive assisted living services. R4's Service Plan - Modification dated December 10, 2024, indicated R4 received services including ambulation, appointment reminders, bathing assistance, deep room cleaning, dressing assistance, escort assistance, grooming assistance, incontinence care, laundry assistance, behavior management, assistance with meals, medication administration, vital signs, safety checks, and toileting assistance. R2, R3, and R4's service plan lacked the following content: - schedule of monitoring assessments of a resident; - the schedule and methods of monitoring staff providing services; and, - a contingency plan that includes: - the action to be taken if the scheduled service cannot be provided - information and a method to contact the facility - the names and contact information of persons the resident wishes to have notified in an	01650		

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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
01650	Continued From page 40 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 - 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. On December 11, 2024, at 11:23 a.m., agent (A)-A stated there was some confusion on how to access original service plans using RTasks (a web-based application for helathcare management). A-A stated they would contact RTasks for additional training on accessing the document created by RTasks that contained all required content. On December 11, 2024, at 3:10 p.m., clinical nurse supervisor (CNS)-B stated they would complete additional training so they could figure out how to access required documents on RTasks. The licensee's undated Service Policy and Procedure document indicated the following: "The service plan must include: - 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; - the identification of staff or categories of staff who will provide the services; - the schedule and methods of monitoring assessments of the resident; - the schedule and methods of monitoring staff providing services; and - a contingency plan that includes:	01650		

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	40105	A. BUILDING: _____ B. WING _____	12/12/2024

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01650	Continued From page 41 a. the action to be taken if the scheduled service cannot be provided; b. information and a method to contact the facility; c. 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 d. 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." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650		
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's	01730		

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01730	Continued From page 42 directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop an individualized medication management record with the required content for four of four residents (R2, R3, R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and	01730		

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01730	Continued From page 43 was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R2 R2 admitted to the licensee on June 4, 2024, to receive assisted living services. R2's Service Plan - Modification signed December 10, 2024, indicated R2 received assistance with ambulation, bathing assistance, bedmaking, deep room cleaning, assistance with dressing in the morning and evening, drinking assistance, glasses care, grooming, housekeeping, incontinence care, laundry, behavior management, positioning and repositioning, vital signs, safety checks, assistance with transfers, and wheelchair use. R3 R3 admitted to the licensee on December 6, 2024, to receive assisted living services. R3's unsigned Service Plan - Modification document indicated R3 received assistance with ambulation, appointment reminders, beathing assistance, bed making, deep room cleaning, dressing assistance in the morning and evening, drinking assistance, care of diabetic equipment, assistance with escorts, grooming, incontinence care, laundry, behavior management, meal assistance, medication administration, nail care, vital signs, and toileting assistance. R4 R4 admitted to the licensee on July 28, 2024, to receive assisted living services.	01730		

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01730	Continued From page 44 R4's Service Plan - Modification dated December 10, 2024, indicated R4 received services including ambulation, appointment reminders, bathing assistance, deep room cleaning, dressing assistance, escort assistance, grooming assistance, incontinence care, laundry assistance, behavior management, assistance with meals, medication administration, vital signs, safety checks, and toileting assistance. R2, R3, and R4's Medication Management Plans lacked the following: - person responsible for monitoring medication supplies and refills. On December 11, 2024, at 3:00 p.m., clinical nurse supervisor (CNS)-B stated they were unaware the information was missing from resident records and was also not aware it was required information. CNS-B stated staff were trained to contact nursing when residents were running low or out of medications. The licensee's undated Medication Management Policy and Procedure document indicated the individualized medication management plan must contain identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all	01880		

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01880	Continued From page 45 prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to store all prescription medications securely to permit only authorized personnel to have access. 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 December 10, 2024, during continuous observation from 7:31 a.m., to 8:22 a.m., the surveyor observed unlicensed personnel (ULP)-E administer medications to all residents residing within the facility. At 7:31 a.m., the surveyor observed ULP-E unlock the licensee's medication cabinet and prepare medications for R2. After preparing medications, ULP-E left the licensee's medication cabinet unlocked and unattended while administering medications to R2 at 7:34 a.m. From 7:44 a.m., to 7:53 a.m., ULP-E again left the licensees medication cabinet unlocked and unattended while administering medications to R4. From 8:00 a.m., to 8:05 a.m., ULP-E left the licensees medication cabinet unlocked and unattended while assisting R3 in the bathroom.	01880		

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01880	Continued From page 46 On December 11, 2024, at 10:48 a.m., ULP-E stated they were trained to secure medications. ULP-E stated it was their first time being observed by a surveyor and they had become nervous during the observed medication pass. On December 11, 2024, at 11:27 a.m., agent (A)-A stated all staff were trained to keep medication cabinets secure at all times. On December 11, 2024, at 3:14 p.m., clinical nurse supervisor (CNS)-B stated leaving the medication unsecured was unacceptable and staff were expected to secured medications after preparing medications. The licensee's undated medication management policy titled "[licensee] Medication Management Policy and Procedure" indicated the licensee must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated	01890		

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01890	Continued From page 47 drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were maintained bearing the original prescription label with legible information for two of three residents (R2, R4) and failed to ensure time sensitive medications were labeled with the date opened for one of three 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 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: MEDICATION STORAGE On December 9, 2024, at 12:55 p.m., during an audit of the licensee's medication storage cabinet, the surveyor observed three tablets and one capsule of unidentified medications. The medications were found in the bottom of the medication bin belonging to R4. On December 9, 2024, at 12:59 p.m., during an audit of the licensee's medication storage cabinet, the surveyor observed a card of Hyoscyamine Sub 0.125mg belonging to R4 with a damaged and illegible medication label. TIME SENSITIVE MEDICATIONS	01890		

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01890	Continued From page 48 On December 9, 2024, at 12:23 p.m., during an audit of the licensee's medications storage cabinet, the surveyor observed an opened insulin pen belonging to R3 containing insulin Aspart that lacked an opened-on date. The manufacturer's instructions printed on the side of the box indicated to discard the pen after 28 days of use. On December 9, 2024, at 1:10 p.m., clinical nurse supervisor (CNS)-B stated staff were trained to label insulin syringes with opened on dates when opening the medication. On December 9, 2024, at 1:16 p.m., CNS-B stated all staff were trained to document and dispose of loose medications found in bins. The licensee's undated medication management policy titled "[licensee] Medication Management Policy and Procedure" indicated that medications must be stored according to manufacturer's directions, all controlled mediations are to be double locked, and medications must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
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	01910		

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01910	Continued From page 49 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 the date of disposition and names of staff and other individuals involved in the disposition for one of two discharged residents (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).	01910		

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01910	Continued From page 50 The findings include: R1 discharged from the licensee on February 7, 2024. R1's record lacked documentation of 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. On December 9, 2024, oat 11:32 a.m., agent (A)-A stated the licensee did not complete a discharge on R1, but instead treated it as a transfer, as R1 had moved into an affiliated facility. The licensee's undated medication management policy titled "[licensee] Medication Management Policy and Procedure" indicated that 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. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		

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

Type: Full
Date: *12/09/24*
Time: 13:00:00
Report: 1013241137

Food and Beverage Establishment Inspection Report

Location:
EVERGREEN ASSISTED LIVING CARE
6629 XERXES AVENUE SOUTH
Richfield, MN55423
Hennepin County, 27

Establishment Info:
ID #: 0043827
Risk:
Announced Inspection: No

License Categories:

Expires on: 12/31/24

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.

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

Hot Water: = at 160 Degrees Fahrenheit
Location: Dish machine
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Turkey deli meat
Temperature: 41 Degrees Fahrenheit - Location: Refrigerator
Violation Issued: No

Process/Item: Cooked pasta
Temperature: 41 Degrees Fahrenheit - Location: Refrigerator - prepared 12/9/24 for same day service
Violation Issued: No

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

The inspection was completed with the operator then reviewed with MDH Nurse Evaluator Z. Morth.

The establishment has a residential kitchen and serves food that is prepared that day. The kitchen has laminate cabinets, tile floor, tile walls, solid counter top, and a textured painted ceiling.

A two basin sink is located in the kitchen. One basin is designated for hand washing. **Water pressure was low at the kitchen sink. Have a plumber repair the faucet.**

A residential dish machine is used to wash ware. The dish machine is run on the sanitize/high temperature cycle.

Discussed hand washing, ware washing, staff illness policy, temperature control, final cook temperatures,

cleaning, serving highly susceptible populations, glove use, food storage, and food handling procedures.

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 1013241137 of 12/09/24.

Certified Food Protection Manager: Sunny Kim

Certification Number: 54295 Expires: 11/24/27

Inspection report reviewed with person in charge and emailed.

Signed: _____

Ashley Pitts, Eunie Buford
Operators

Signed: JM

Jerry Malloy
Sanitarian Supervisor
FPLS Metro
651-201-3998
jerry.malloy@state.mn.us