



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

June 23, 2025

Licensee
Second Horizon Living LLC
7609 Modern Road
Brooklyn Park, MN 55428

RE: Project Number(s) SL38164016

Dear Licensee:

On April 29, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on January 22, 2025, and the follow-up survey completed on March 21, 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,

A handwritten signature in black ink, appearing to read 'Tim Hanna'.

Tim Hanna, Supervisor
State Engineering Services Section
Health Regulation Division
Email: Tim.Hanna@state.mn.us
Telephone: 507-208-8982 Fax: 1-866-890-9290

JMD



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

April 18, 2025

Licensee

Second Horizon Living LLC

7609 Modern Road

Brooklyn Park, MN 55428

RE: Project Number(s) SL38164016

Dear Licensee:

On March 21, 2025, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on November 14, 2024, and the follow-up survey completed on January 22, 2025. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the November 14, 2024 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on November 14, 2024, found not corrected at the time of the March 21, 2025, follow-up survey and/or subject to penalty assessment are as follows:

0780 - Fire Protection And Physical Environment - 144g.45 Subd. 2 (a) (1)

The details of the violations noted at the time of this follow-up survey completed on March 21, 2025 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

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

DOCUMENTATION OF ACTION TO COMPLY

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

IMPOSITION OF FINES:

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.

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:

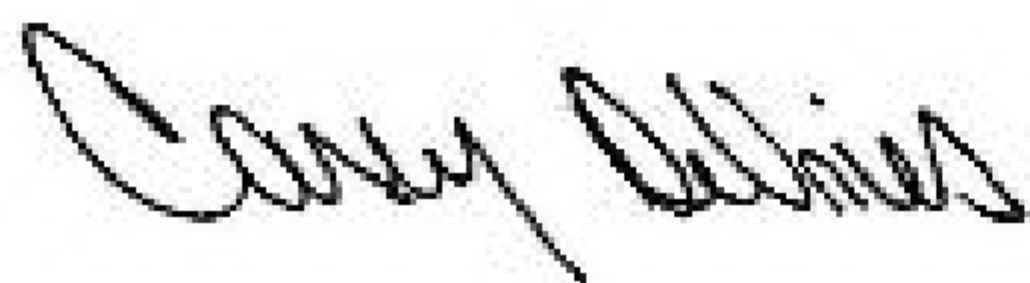
<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

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.

We urge you to review these orders carefully. If you have questions, please contact Casey DeVries at 651-201-5917.

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

Sincerely,



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

JMD

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 38164	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 03/21/2025
NAME OF PROVIDER OR SUPPLIER SECOND HORIZON LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 7609 MODERN ROAD BROOKLYN PARK, MN 55428		
(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 FOLLOW UP SURVEY WITH RE-ISSUE OF ORDERS INITIAL COMMENTS SL38164016-2 On March 20, 2025, through March 21, 2025, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on January 22, 2025. At the time of the survey, there were three (3) residents receiving services under the Assisted Living License. As a result of the follow-up survey, the following orders were reissued.	{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}			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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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:	{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 must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626.	{0 480}	Not reviewed during this survey.		

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{0 480}	Continued From page 2 (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 and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant	{0 480}			

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{0 480}	Continued From page 3 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:	{0 480}	Not reviewed during this survey.		
{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 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:	{0 485}			
{0 630} SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma	{0 630}	Not reviewed during this survey.		

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{0 630}	Continued From page 4 (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; 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:	{0 630}	Not reviewed during this survey.		
{0 650} SS=F	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living	{0 650}			

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{0 650}	Continued From page 5 services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by:	{0 650}	Not reviewed during this survey.		
{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 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:	{0 660}			
{0 680} SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements:	{0 680}	Not reviewed during this survey.		

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{0 680}	Continued From page 6 (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:	{0 680}	Not reviewed during this survey.		
{0 780} SS=E	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	{0 780}			

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{0 780}	Continued From page 7 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 provide facilities that were not a distinct hazard to life and failed to keep the facility in compliance with the Minnesota Fire Code. This had the potential to directly affect all of the residents and staff. 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 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 20, 2025, at 10:00 a.m., unlicensed	{0 780}			

Minnesota Department of Health

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{0 780}	Continued From page 8 personnel (ULP)-B provided the surveyor with a tour of the facility to review window installation progress. ULP-B stated two (2) new windows were recently installed in unoccupied rooms, but the new windows had not been installed in two of the occupied rooms. The surveyor noted two new uninstalled windows were stored in unoccupied bedroom 2. Newly installed windows in unoccupied bedroom 1 and 2 exceeded minimum requirements for opening and square inches. ULP-B stated staff conducted fire watches every 30 minutes and documented the fire watch. The surveyor reviewed the fire watch documentation with start date of January 5, 2025, and observed ULP-B document fire watch findings accurately. Windows in occupied sleeping bedrooms 3 and 4 emergency escapes and rescue clear window opening measurements were 35" X 16" X 46". The resident rooms were on the upper level of the home. The windows did not meet the 20 inches minimum requirements for height and did not meet the 648 square inch total. On March 20, 2025, at 10:50 a.m., owner (O)-G stated licensee had windows installed in the 2 unoccupied rooms first, then planned to have residents temporarily move from non-compliant bedrooms 3 and 4 into compliant bedrooms 1 and 2. After residents had successfully relocated into bedrooms 1 and 2, the new windows were to be installed in bedrooms 3 and 4. O-G stated they expected installers to return within two weeks to complete the installation of the windows in bedroom 3 and 4 and then residents would have the option to return to their original room or would be given the option to remain in the rooms they were temporarily moved to. No further information was provided.	{0 780}			

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{0 790} SS=F	144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by:	{0 790}	Not reviewed during this survey.		
{0 810} SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) 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	{0 810}			

Minnesota Department of Health
STATE FORM 6899 XG0D13 If continuation sheet 11 of 16

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{0 940}	Continued From page 11	{0 940}			
{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 Adult Abuse Reporting Center.	{0 940}			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
{0 940}	Continued From page 12 This MN Requirement is not met as evidenced by:	{0 940}	Not reviewed during this survey.		
{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 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:	{01530}			

Minnesota Department of Health

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{01620}	Continued From page 13	{01620}	Not reviewed during this survey.		
{01620} SS=F	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:	{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	{01650}			

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{01650}	Continued From page 14 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 by:	{01650}	Not reviewed during this survey.		
{01890} SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug.	{01890}			

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{01890}	Continued From page 15 This MN Requirement is not met as evidenced by:	{01890}	Not reviewed during this survey.		



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
February 27, 2025

Licensee
Second Horizon Living LLC
7609 Modern Road
Brooklyn Park, MN 55428

RE: Project Number(s) SL38164016

Dear Licensee:

On January 22, 2025, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on November 14, 2024. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the November 14, 2024 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on November 14, 2024, found not corrected at the time of the January 22, 2025, follow-up survey and/or subject to penalty assessment are as follows:

0780 - Fire Protection And Physical Environment - 144g.45 Subd. 2 (a) (1) - \$500.00

1290 - Background Studies Required - 144g.60 Subdivision 1 - \$3,000.00

The details of the violations noted at the time of this follow-up survey completed on January 22, 2025 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$3,500.00**. 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 outlined on the state form; however, plans of correction are not required to be submitted for approval.

IMPOSITION OF FINES:

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.

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:

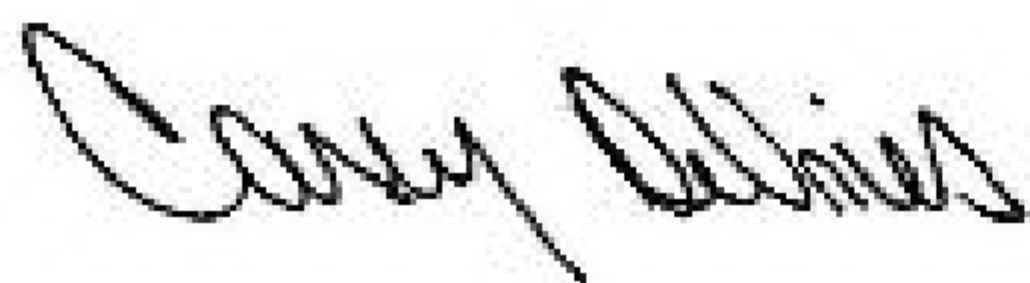
<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

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.

We urge you to review these orders carefully. If you have questions, please contact Casey DeVries at 651-201-5917.

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

Sincerely,



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

JMD

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 38164	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 01/22/2025
NAME OF PROVIDER OR SUPPLIER SECOND HORIZON LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 7609 MODERN ROAD BROOKLYN PARK, MN 55428		
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{0 000}	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER FOLLOW UP SURVEY WITH RE-ISSUE OF ORDERS INITIAL COMMENTS SL38164016-1 On January 22, 2025, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on November 14, 2024. At the time of the survey, there were two residents both received services under the Assisted Living License. As a result of the follow-up survey, the following orders were reissued.	{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}			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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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:	{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 must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626.	{0 480}	Not reviewed during this survey.		

Minnesota Department of Health

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{0 480}	Continued From page 2 (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 and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant	{0 480}			

Minnesota Department of Health

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{0 480}	Continued From page 3 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:	{0 480}	Not reviewed during this survey.		
{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 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:	{0 485}			
{0 630} SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma	{0 630}	Not reviewed during this survey.		

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{0 630}	Continued From page 4 (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; 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:	{0 630}	Not reviewed during this survey.		
{0 650} SS=F	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living	{0 650}			

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{0 650}	Continued From page 5 services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by:	{0 650}	Not reviewed during this survey.		
{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 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:	{0 660}			
{0 680} SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements:	{0 680}	Not reviewed during this survey.		

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{0 680}	Continued From page 6 (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:	{0 680}	Not reviewed during this survey.		
{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	{0 780}			

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{0 780}	Continued From page 7 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 provide facilities that were not a distinct hazard to life and failed to keep the facility in compliance with the Minnesota Fire Code. This had the potential to directly affect all of the residents and staff. 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: HAZARD TO LIFE On January 22, 2025, at 9:35 a.m., with	{0 780}			

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{0 780}	Continued From page 8 unlicensed personnel (ULP)-B, the surveyor observed compliant emergency escape and rescue openings were not provided in resident sleeping rooms 1, 2, 3, and 4 in the upper level of the facility. ULP-B stated since the previous survey the licensee hired a contractor to replace the windows in room 1, 2, 3, and 4 however, the contractor went out of the country for a trip and then the weather became too cold to install the new windows. ULP-B stated they believed the windows would be installed in the next few days. ULP-B stated staff conducted fire watches every 30 minutes and documented the fire watch. The surveyor observed the fire watch documentation between the previous survey and the current survey. OCCUPIED RESIDENT ROOMS Resident sleeping rooms 3 emergency escape and rescue clear window opening measurements are 35" X 16" X 46". The resident room is on the upper level of the home. The windows do not meet the 20 inches minimum requirements for height and do not meet the 648 square inch total. UNOCCUPIED RESIDENT ROOMS Resident sleeping rooms 1, 2, and 4 emergency escape and rescue clear window opening measurements are 35" X 16" X 46". These resident rooms are on the upper level of the home. The windows do not meet the 20 inches minimum requirements for height and do not meet the 648 square inch total. Existing emergency escape and rescue openings are required to meet a minimum clear opening area of 648 square inches and have a minimum dimension of 20 inches in height and a minimum	{0 780}			

Minnesota Department of Health

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{0 780}	Continued From page 9 dimension of 20 inches in width. The windowsill height from the floor to the clear opening shall be not more than 48 inches. These deficient conditions were visually verified ULP-B accompanying on the tour and verbally verified by licensed assisted living director (LALD/LPN)-D. On January 22, 2025, at 9:52 a.m., LALD/LPN-D stated the licensee chose a contractor they could afford to replace the windows. LALD/LPN-D stated the contractor was supposed to replace the windows last week however, due to the cold weather conditions they were not able to be replaced. On January 22, 2025, at 10:37 a.m., LALD/LPN-D provided the surveyor with a diagram of the upper level of the facility and stated the diagram was the plan they submitted to receive permits for the windows. On January 22, 2025, at 11:42 a.m., LALD/LPN-D provided a contract the licensee had with the contractor. FIRE CODE On January 22, 2025, at 10:27 a.m., the surveyor observed an orange extension cord was routed through the door in the office in the lower level, and an extension cord connected to a power strip connected to the TV in the lower level. The surveyor explained to LALD/LPN-D that electrical cords shall not be routed through walls/doors and shall not be used for permanent use.	{0 780}			

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{0 780}	Continued From page 10 On January 22, 2025, at 11:51 a.m., LALD/LPN-D stated the licensee fixed two outlets from the previous survey that used extension cords. LALD/LPN-D stated they have not fixed the two listed above because each of the outlets costed 500 dollars and with the licensee's low census the licensee was fixing what they could afford however, the licensee would continue to work on the other two outlets as funds became available. The deficient conditions were visually verified by LALD/LPN-D accompanying on the tour. No further information was provided.	{0 780}			
{0 790} SS=F	144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by:	{0 790}			
{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	{0 810}	Not reviewed during this survey.		

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{0 810}	Continued From page 11 plans shall include but are not limited to: (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:	{0 810}			
{0 910} SS=C	144G.50 Subd. 2 (a-b) Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name	{0 910}	Not reviewed during this survey.		

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{0 910}	Continued From page 12 and the health facility identification of the facility. (b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility. This MN Requirement is not met as evidenced by:	{0 910}	Not reviewed during this survey.		
{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;	{0 940}			

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{0 940}	Continued From page 13 (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 Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by:	{0 940}	Not reviewed during this survey.		
{01290} SS=G	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits.	{01290}			

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{01290}	Continued From page 14 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a background study clearance was submitted and received in affiliation with the assisted living license for one of seven employees (unlicensed personnel (ULP)-E). 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 finding include: The licensee's plan of correction printed December 20, 2024, indicated on November 14, 2024, all missing background studies for employees were completed. ULP-E was hired on September 16, 2024, to provide direct care services to residents. The licensee's RTasks (documenting software program) dated December 11, 2024, indicated ULP-E administered medications to R2. On January 22, 2025, at 10:12 a.m., the surveyor observed the licensee's Minnesota Department of Human Services (DHS) NETStudy 2.0 (a web-based system used to submit background study requests) roster for HFID# 38164 and observed ULP-E was not listed on the roster.	{01290}			

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{01290}	Continued From page 15 On January 22, 2025, at 11:04 a.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-D stated ULP-E was removed from the licensee's NETStudy 2.0 roster, and they did not know why. On January 22, 2025, at 11:10 a.m., the surveyor observed NETStudy 2.0 for ULP-E and observed ULP-E was affiliated to the licensee on November 14, 2024, and separated from the licensee's roster due to no consent received on November 29, 2024. On January 22, 2025, at 11:22 a.m., LALD/LPN-D stated they believed the only consent needed to be filled out was the consent from the licensee to conduct a background study. LALD/LPN-D stated after the previous survey they left the country, and the licensee's clinical nurse supervisor (CNS) told them all of the licensee's employees background study were completed. LALD/LPN-D stated when the licensee received a clearance letter from DHS for the employee, it would be placed in the employee record. The surveyor requested a copy of the clearance letter. Although requested the surveyor did not receive the clearance letter prior to the completion of the survey. The licensee's undated Background Studies policy indicated each facility employee, volunteer, and contractor who would provide direct care to residents must have a background study completed. In addition, employees may not work until the results of the background study have been received unless the employee was under direct continuous supervision of the employer. No further information was provided.	{01290}			

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{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 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:	{01530}			
{01620} SS=F	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	{01620}	Not reviewed during this survey.		

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{01620}	Continued From page 17 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:	{01620}	Not reviewed during this survey.		
{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	{01650}			

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{01650}	Continued From page 18 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 by:	{01650}	Not reviewed during this survey.		
{01890} SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by:	{01890}			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

December 20, 2024

Licensee
Second Horizon Living LLC
7609 Modern Road
Brooklyn Park, MN 55428

RE: Project Number(s) SL38164016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on November 14, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

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 - 1290 - 144g.60 Subdivision 1 - Background Studies Required - \$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

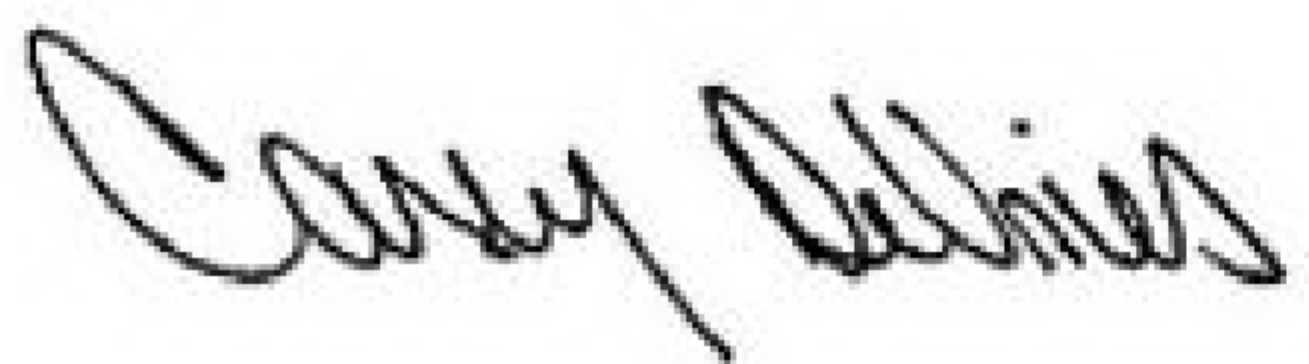
the website listed above.

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,

A handwritten signature in black ink, appearing to read "Casey DeVries". The signature is written in a cursive, flowing style.

Casey DeVries, Supervisor

State Evaluation Team

Email: Casey.DeVries@state.mn.us

Telephone: 651-201-5917 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER SECOND HORIZON LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 7609 MODERN ROAD BROOKLYN PARK, MN 55428		
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0 000	Initial Comments ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL38164016-0 On November 12, 2024, through November 14, 2024, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were three residents all of whom received services under the Assisted Living Facility license. On November 14, 2024, an immediate correction order was issued for tag identification number 1290.	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			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 38164	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/14/2024
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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 interview and record review, the licensee failed to develop and implement a written staffing plan that included an evaluation completed by the clinical nurse supervisor (CNS) (as indicated in Minnesota Administrative Rule 4659.0180) at least twice a year. 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	0 470			

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0 470	Continued From page 2 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee held an assisted living license. The facility was licensed for a capacity of five residents. The licensee's Direct Care Staffing Plan signed October 15, 2024, indicated one unlicensed personnel worked on the a.m., p.m., and overnight shifts. During weekdays (Monday through Friday) there was a part-time registered nurse (RN) and licensed practical nurse (LPN), and during the evening hours and weekend there was one on call RN and one on call LPN. The document indicated the staffing plan was reviewed one time and lacked a second review completed by the CNS. On November 13, 2024, at 12:14 p.m., CNS-C stated they started employment in October and reviewed the staffing plan. CNS-C stated they planned to review the staffing plan monthly due to staff turnovers. On November 13, 2024, at 1:25 p.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-D stated a RN who no longer worked for the licensee created and reviewed the staffing plan however, the licensee lacked documentation of any reviews conducted by the RN. No further information was provided.	0 470			

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0 470	Continued From page 3	0 470			
0 480 SS=F	TIME PERIOD FOR CORRECTION: Seven (7) days 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 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	0 480			

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0 480	Continued From page 4 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. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report	0 480			

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0 480	Continued From page 5 (FBEIR) dated November 12, 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 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	0 485			

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0 485	Continued From page 6 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 November 13, 2024, at 1:25 p.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-D stated the blank contract titled Resident Contract for Assisted Living was provided to all residents who resided at the facility. The licensee's contract included a section titled Attachment A Fee Schedule - Assisted Living Facility and indicated "This Assisted Living Facility offers all of the following (included in the Month Base Fee): - At least three meals daily with snacks available seven (7) days per week" The contract included verbiage to require residents to pay for their meals as part of their assisted living package fee. LALD/LPN-D stated they were unaware the contract could not include verbiage to include meals as part of their base fees. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485			
0 630 SS=D	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	0 630			

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0 630	Continued From page 7 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; 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 the required content for one of two 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). The findings include: R1 admitted to the licensee on June 8, 2020, under the licensee's former comprehensive license and began receiving assisted living services on August 1, 2021. R1's Planned Services signed October 4, 2024, indicated R1 received assistance with activities, verbal reminders to bathe, grooming, housekeeping, laundry, behavior management, socialization, medication administration, and safety checks.	0 630			

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0 630	Continued From page 8 R1's Individual Abuse Prevention Plan dated August 20, 2024, indicated R1 was at risk to be abused by others and R1 had a history of agitation, property destruction, repetitive behaviors, sexually inappropriate behaviors, and verbal aggression. R1's IAPP record lacked an individualized review or assessment of the resident's risk of abusing other vulnerable adults, and the specific measures to be taken to minimize the risk of abuse to the resident or other vulnerable adults and risk of self-abuse. On November 13, 2024, at 12:14 p.m., clinical nurse supervisor (CNS)-C stated the licensee assessed if residents were at risk to be abused or to abuse others and if they were at risk they would add interventions to decrease the risk of occurrence. CNS-C stated they were unsure why R1's record lacked the above content because they were recently hired, and they had not conducted a resident assessment on R1. CNS-C stated from interactions they had with R1 they did not believe they were at risk for abusing others. The licensee's undated Abuse Prevention Plan indicated all residents admitted to the licensee would be assessed for their susceptibility to abuse by other individuals, including other vulnerable adults and their risk of abusing other vulnerable adults. The licensee would develop a statement of the specific measures that would be taken to minimize the risk of abuse to that person and other vulnerable adults. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630			

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

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0 650	Continued From page 10 resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee did not have any sister facilities affiliated with the same corporate organization as the licensee. CNS-C CNS-C was hired on October 1, 2024, to provide supervision and oversight to ULP and to provide direct care services to residents. CNS-C's employee record included an undated EduCare (a training software) transcript which included a guide to assisted living completed November 9, 2021, prior to hire. CNS-C's employee record lacked the following orientation: - overview of assisted living statutes; - reporting maltreatment of vulnerable adults; - consumer advocacy services; - review of types of assisted living services the employee would provide and provider's scope of license; and - principle of person-centered planning/service delivery. ULP-B ULP-B's record included an undated EduCare transcript which included a guide to assisted living course completed July 19, 2022, and November 1, 2023, prior to hire. ULP-B's employee record lacked the following orientation: - overview of assisted living statutes; - reporting maltreatment of vulnerable adults;	0 650			

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0 650	Continued From page 11 - consumer advocacy services; - review of types of assisted living services the employee would provide and provider's scope of license; and - principle of person-centered planning/service delivery. - 30-day supervision. On November 13, 2024, at 6:40 a.m., the surveyor observed ULP-B was the only employee in the licensee's facility. On November 13, 2024, at 10:13 a.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-D stated they believed they could transfer all EduCare courses from a different licensee to their facility unless the information was site specific. LALD/LPN-D stated ULP-B and CNS-C received the orientation topics listed above in person however, the licensee's templated documents did not include the topics and they did not have documentation on the topics listed above. On November 13, 2024, at 11:24 a.m., ULP-B stated they received training on all the orientation topics listed above in person by LALD/LPN-D upon hire. In addition, ULP-B stated they received a 30-day supervision by CNS-C. On November 13, 2024, at 12:22 p.m., CNS-C stated they received training on all the orientation topics listed above in person by LALD/LPN-D upon hire. The licensee's undated Personnel Records policy indicated the personnel record for an employee shall include record of orientation to the facility and records of annual training including infection control training and competency evaluations.	0 650			

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0 650	Continued From page 12 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650			
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 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 observation, 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 (unlicensed personnel (ULP)-B). This practice resulted in a level two violation (a	0 660			

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0 660	Continued From page 13 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 July 1, 2024, indicated the facility was at a low risk level. ULP-B was hired on September 2, 2024, to provide direct care services to residents. ULP-B's employee record included a health history screening dated August 28, 2024, and a QuantiFERON Gold blood test with a negative test result dated October 21, 2023. The test was completed 317 days prior to ULP-B's date of hire. On November 13, 2024, at 6:40 a.m., the surveyor observed ULP-B was the only employee in the licensee's facility. On November 13, 2024, at 12:19 p.m., clinical nurse supervisor (CNS)-C stated employees completed a TB screening upon hire. CNS-C stated they were unsure of the licensee's process for obtaining the TB screen because they were recently hired however, they believed every employee was up to date. The surveyor inquired if the employee brought a TB screen from a different facility, how many days prior to the date of hire would they accept the completed TB screen. CNS-C stated they would have to review their policy; however, they believed it was a year.	0 660			

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NAME OF PROVIDER OR SUPPLIER SECOND HORIZON LIVING LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 7609 MODERN ROAD BROOKLYN PARK, MN 55428			
(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
0 660	Continued From page 14 On November 14, 2024, at 9:01 a.m., CNS-C stated they were not aware if an employee provided a previous TB health screen it could only be accepted if it was completed within 90 days before hire. The CDC document titled Clinical Testing Guidance for Tuberculosis Health Care Personnel dated December 15, 2023, indicated all health personnel should be screened for TB upon hire. The Minnesota Department of Health Tuberculosis Screening FAQ, dated October 15, 2024, indicated a TST or blood test completed prior to hire would be acceptable if it was completed within 90 days before hire date. The licensee's undated Tuberculosis Screening policy indicated each employee must have documentation of a baseline health symptom screening prior to providing care to residents. 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 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 15 (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). The findings include: The licensee failed to post an emergency disaster plan prominently. In addition, the licensee's	0 680			

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0 680	Continued From page 16 emergency disaster preparedness plan dated May 25, 2024, lacked evidence of the following required content: - consideration of emerging infectious diseases; - hazard vulnerability risk assessment; - quarterly review of the missing resident plan; - emergency plan (EP) program for resident population to include transportation, which staff would assume specific roles in another's absence through succession planning and delegation of authority, and who is the qualified person who is authorized in writing to act in absence of the administrator; - process for EP collaboration - subsistence needs for staff and residents; - procedures for tracking staff and residents; - policies and procedures for evacuations including transportation and identification of primary and alternative locations; - policies and procedures for sheltering in place; - policies and procedures for medical documents; - policies and procedures for volunteers; - arrangement with other facilities to included written arrangement agreements; - roles under a waiver declared by secretary; - development of a communication plan; - names and contact information; - emergency officials contact information; - methods for sharing information; - sharing information on occupancy needs; and - long term care family notifications. On November 12, 2024, at 1:32 p.m., licensed assisted living director/licensed practical nurse LALD/LPN-D stated they did not have the EPP located at the facility, and they provided the surveyor the information they printed off the computer of what content was in the EPP binder. LALD/LPN-D stated if there was an evacuation, the residents would evacuate to the nearest hotel	0 680			

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0 680	Continued From page 17 and the licensee did not have an agreement with the hotel. On November 14, 2024, at 9:23 a.m., LALD/LPN-D stated they were unaware the EPP should contain information on sewage and waste removal and roles under waiver declared by secretary. The licensee's undated Hazard Vulnerability Analysis policy indicated the hazard vulnerability assessment would be conducted initially when developing the EPP, upon identification of any new external risk factor, when beginning a new service, and annually. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			
0 780 SS=I	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is	0 780			

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0 780	Continued From page 18 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 provide facilities that were not a distinct hazard to life and failed to keep the facility in compliance with the Minnesota Fire Code. This had the potential to directly affect all of the residents and staff. 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 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 a facility tour on November 12, 2024, between 11:45 a.m. and 2:00 p.m. with licensed assisted living director/licensed practical nurse (LALD/LPN)-D, the surveyor observed that compliant emergency escape and rescue openings were not provided in resident sleeping rooms 1, 2, 3 and 4 in the upper level of the facility.	0 780			

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0 780	Continued From page 19 OCCUPIED RESIDENT ROOMS Resident sleeping rooms 3 and 4 emergency escape and rescue clear window opening measurements are 35" X 16" X 46". These resident rooms are on the upper level of the home. The windows do not meet the 20 inches minimum requirements for height and do not meet the 648 square inch total. The windows were measured by the surveyor with the LALD/LPN-D present. UNOCCUPIED RESIDENT ROOMS Resident sleeping rooms 1 and 2 emergency escape and rescue clear window opening measurements are 35" X 16" X 46". These resident rooms are on the upper level of the home. The windows do not meet the 20 inches minimum requirements for height and do not meet the 648 square inch total. The windows were measured by the surveyor with the LALD/LPN-D present. It was explained to LALD/LPN-D that at least one compliant emergency escape and rescue opening is required within each resident sleeping room. Existing emergency escape and rescue openings are required to meet a minimum clear opening area of 648 square inches and have a minimum dimension of 20 inches in height and a minimum dimension of 20 inches in width. The windowsill height from the floor to the clear opening shall be not more than 48 inches. These deficient conditions were visually verified LALD/LPN-D accompanying on the tour. The surveyor explained that an immediate correction	0 780			

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0 780	Continued From page 20 order will be issued for the above findings. TIME PERIOD FOR CORRECTION: Immediate NON-IMMEDIATE ORDERS: Based on observation and interview, the licensee failed to keep the facility in compliance with the Minnesota Fire Code. The deficient condition has 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 a facility tour on November 12, 2024, between 11:45 a.m. and 2:00 p.m., with licensed assisted living director/licensed practical nurse (LALD/LPN)-D, the surveyor observed the following conditions: EMERGENCY ESCAPE AND RESCUE OPENINGS: The surveyor observed that the emergency escape window in the resident room 5 in the lower level could not fully open because the window well cover was blocking it. The LALD/LPN-D removed the cover and the window opened properly. The surveyor explained to LALD/LPN-D that	0 780			

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0 780	Continued From page 21 emergency escape window shall be always fully openable. SMOKE ALARMS: The surveyor observed that the 120-volt smoke alarm in resident room 5 was missing and that the 120-volt smoke alarm inside and outside of this room were 120-volt smoke alarms and they were not interconnected with the rest of the alarms in the facility. The surveyor explained to LALD/LPN-D that all smoke alarms shall be always kept in place and operable and that the 120-volt smoke alarms shall be interconnected with the battery smoke alarms in the facility so that when one sounds, they all sound. ELECTRICAL/EXTENSION CORDS: The surveyor observed an orange extension cord was routed through the door in the office in the lower level, that a brown extension cord was routed to the TV in the lower level, that a power strip cord was routed through a door into the mechanical room and that the doorbell transformer was wired outside of a light electrical box in the mechanical room. The surveyor explained to the LALD/LPN-D that electrical cords shall not be routed through walls/doors and shall not be used for permanent use. Also, all electrical connections shall be made in a code compliant junction box. FIRE RATING: The surveyor observed missing gypsum board in the ceiling in the garage. The surveyor could see	0 780			

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0 780	Continued From page 22 into the attic space above the facility. The surveyor explained to the LALD/LPN-D that the gypsum board shall be replaced so that the ceiling is covered with no openings to the attic. The deficient conditions were visually verified by LALD/LPN-D accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780			
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the portable fire extinguishers. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	0 790			

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0 790	Continued From page 23 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 finding include: On a facility tour on November 12, 2024, between 11:45 a.m. and 2:00 p.m. with licensed assisted living director/licensed practical nurse (LALD/LPN)-D, the surveyor observed that the portable fire extinguishers in the facility needed to have their annual and monthly inspections completed. The surveyor explained to the LALD/LPN-D that all fire extinguishers shall inspected monthly and annually to meet the state fire code requirements. The deficient condition was visually verified by the LALD/LPN-D accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790			
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement,	0 810			

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0 810	Continued From page 24 evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content. 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 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).	0 810			

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0 810	Continued From page 25 The findings include: A record review and interview were conducted on November 12, 2024, at approximately 1:00 p.m. with the licensed assisted living director/licensed practical nurse (LALD/LPN)-D on the fire safety and evacuation plan, training records and fire drills for the facility. FIRE DRILLS: During record review the surveyor observed that the fire drills had not been completed and documented on all shifts. The LALD/LPN-D stated they had conducted some fire drills and there is documentation showing this, but not twice a year on each shift. The surveyor explained to the LALD/LPN-D that evacuation drills are to be completed and documented with employee signatures, twice per year per shift with at least one evacuation drill every month. These fire drills shall be completed with only the number of employees that are normally on that shift. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810			
0 910 SS=C	144G.50 Subd. 2 (a-b) Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name and the health facility identification of the facility. (b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of:	0 910			

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0 910	Continued From page 26 (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility. 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 who resided in the licensee's 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 the potential to affect a large portion or all the residents). The findings include: On November 13, 2024, at 1:25 p.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-D stated the blank contract titled Resident Contract for Assisted Living was provided to all residents who resided at the facility. The licensee's Assisted Living Contract lacked the following required content: - in a conspicuous place and manner on the contract the health facility identification number (HFID#) of the facility. LALD/LPN-D stated the licensee edited the blank contract with the facility's current license number when they issued the contracts upon each resident's admission, however, all contracts would lack a HFID#. LALD/LPN-D stated they	0 910			

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0 910	Continued From page 27 were not aware of the requirement. The licensee's undated Assisted Living Contracts policy indicated the contract must include the legal name and license number of the facility. The policy did not meet current statute requirements. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 910			
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	0 940			

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NAME OF PROVIDER OR SUPPLIER SECOND HORIZON LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 7609 MODERN ROAD BROOKLYN PARK, MN 55428		
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0 940	Continued From page 28 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 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 assisted living contract with all required content. 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 November 13, 2024, at 1:25 p.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-D stated the blank contract titled Resident Contract for Assisted Living was provided to all residents who resided at the facility. The contract lacked the licensee's information on the following content: - a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support	0 940			

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0 940	Continued From page 29 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; and - whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2 paragraph (b). LALD/LPN-D stated the licensee accepted elderly wavier, traumatic brain injury waiver, and community access for disability inclusion (CADI) wavier. LALD/LPN-D stated the licensee did not have an agreement for housing support. The surveyor reviewed the statute with LALD/LPN-D. LALD/LPN-D stated they were unaware of the full requirements needed for the contract. The licensee's undated Assisted Living Contracts policy indicated the contract must include a description of the facility's policies related to medical assistance waivers under 256S and section 256B.49 and the housing support program under 256I, including: - o Whether the facility is enrolled with the commissioner of human services to provide customized living services under medical assistance waivers; and - o Whether the facility has an agreement to provide housing support under section 256I.04, Subdivision 2, paragraph (b). No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 940			
01290 SS=I	144G.60 Subdivision 1 Background studies required	01290			

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01290	Continued From page 30 (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a background study clearance was submitted and received in affiliation with the assisted living license for four of eight employees (unlicensed personnel (ULP)-A, ULP-B, ULP-E, ULP-F). 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 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 finding include: ULP-A ULP-A was hired on December 12, 2022, to provide direct care services to residents.	01290			

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01290	Continued From page 31 On November 12, 2024, at 8:15 a.m., the surveyor observed ULP-A was the only employee in the licensee's facility. ULP-B ULP-B was hired on September 2, 2024, to provide direct care services to residents. On November 13, 2024, at 6:40 a.m., the surveyor observed ULP-B was the only employee in the licensee's facility. ULP-E ULP-E was hired on September 16, 2024, to provide direct care services to residents. The licensee's staff schedule dated November 11-17, 2024, posted on the kitchen refrigerator, indicated ULP-E was the only employee scheduled to work on Monday November 11, 2024, through Friday November 15, 2024, from 3:00 p.m. to 11:00 p.m. ULP-F ULP-F was hired on August 10, 2023, to provide direct care services to residents. The licensee's staff schedule dated November 11-17, 2024, posted on the kitchen refrigerator indicated ULP-F was the only employee scheduled to work on November 16, 2024, from 3:00 p.m. to 7:00 a.m., and November 17, 2024, from 3:00 p.m. to 11:00 p.m. ULP-A, ULP-B, ULP-E, and ULP-F's employee records lacked background study clearance letters submitted and cleared through the Minnesota Department of Human Services NETStudy 2.0 (a web-based system used to	01290			

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01290	Continued From page 32 submit background study requests) system. On November 13, 2024, at 1:09 p.m., after multiple attempts to receive the NETStudy 2.0 roster, the surveyor asked licensed assisted living director/licensed practical nurse (LALD/LPN)-D to open the NETStudy roster for the surveyor. LALD/LPN-D pulled open the roster and stated they would send it to the surveyor via email because they did not have the ability to print the roster at this time. On November 13, 2024, at 1:23 p.m., LALD/LPN-D stated they had hired a person to assist the licensee with paperwork and filing however, the person they hired believed they could complete a background study through an application called the gusto application. LALD/LPN-D stated they did not catch the person was completing background studies on this application for a while. LALD/LPN-D stated completing a background study on the gusto application would not meet the guidelines and there would be issues with the NETStudy 2.0 Roster. On November 14, 2024, at 6:54 a.m., the surveyor observed the licensee's Minnesota Department of Human Services NETStudy 2.0 roster for health facility identification number (HFID#) 38164 and observed no background studies completed for ULP-A, ULP-B, ULP-E, or ULP-F. On November 14, 2024, at 7:40 a.m., LALD/LPN-D stated they were unable to find documentation of the background studies that were completed over the gusto application, and they contacted the person who ran them to try to receive the documentation. LALD/LPN-D stated	01290			

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01290	Continued From page 33 they started to run background studies on the four people listed above and they are all scheduled to be fingerprinted on November 14, 2024. The licensee's undated Background Studies policy indicated each facility employee, volunteer, and contractor who would provide direct care to residents must have a background study completed. In addition, employees may not work until the results of the background study have been received unless the employee was under direct continuous supervision of the employer. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	01290			
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 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	01530			

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01530	Continued From page 34 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 direct-care staff received at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date for one of two direct care employees (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, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-B was hired on September 2, 2024, to provide direct care services to residents. ULP-B was a full-time employee. ULP-B's record included an EduCare (a training software program) transcript that indicated ULP-B received 13.5 hours of dementia care training from May 16, 2019, to July 18, 2022, and received three hours of dementia care training on	01530			

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01530	Continued From page 35 June 5, 2024, from a different licensee. ULP-B was able to transfer three hours of dementia care training from a different licensee to the licensee. ULP-B's record lacked the initial eight hours of dementia care training withing 160 working hours of the employment start date. On November 13, 2024, at 10:13 a.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-D stated they believed they could transfer all EduCare courses from a different licensee to them unless the information was site specific. LALD/LPN-D stated each employee was required to have eight hours of dementia care training. On November 13, 2024, at 12:22 p.m., clinical nurse supervisor (CNS)-C stated employees completed dementia care training on EduCare training upon hire and LALD/LPN-D would assign the employee courses within EduCare. On November 13, 2024, at 1:53 p.m., ULP-B stated they did not receive any dementia care training from the licensee upon hire however, they had taken multiple dementia care courses prior to being hired. ULP-B stated the licensee had them log into their EduCare account and print off their transcript upon hire. The licensee's undated Dementia Care Training policy indicated a direct care employee must have completed at least eight hours of initial dementia care training on required topics within 160 hours from employment start date. In addition, new employees may satisfy the initial dementia care training by producing written proof of previously completed training within the past 18 months. No further information was provided.	01530			

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01530	Continued From page 36	01530			
01620 SS=F	TIME PERIOD FOR CORRECTION: Twenty-one (21) days 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 observation, interview, and record review, the licensee failed to ensure a registered nurse (RN) conducted an assessment as required per Minnesota Administrative Rule 4659.0140 for two of two residents (R1, R2).	01620			

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01620	Continued From page 37 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: R1 R1 admitted to the licensee on June 8, 2020, under the licensee's former comprehensive license and began receiving assisted living services on August 1, 2021. R1's diagnoses included schizophrenia and polysubstance abuse. R1's Planned Services signed October 4, 2024, indicated R1 received assistance with activities, verbal reminders to bathe, grooming, housekeeping, laundry, behavior management, socialization, medication administration, and safety checks. R1's record included a 90-day nursing assessment dated August 20, 2024. The assessment was completed by licensed assisted living director/licensed practical nurse (LALD/LPN)-D. R2 R2 admitted to the licensee on June 24, 2024, and began receiving assisted living services. R2's diagnoses included anxiety, hypertension, mild intellectual disability, seizure disorder, and	01620			

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01620	Continued From page 38 bipolar (a mental illness characterized by extreme mood swings). R2's Planned Services signed June 25, 2024, indicated R2 received assistance with behavior management, safety checks, socialization, medication management, housekeeping, bathing reminders, grooming, and laundry. R2's record included a 90-day nursing assessment dated August 20, 2024. The assessment was completed by LALD/LPN-D. R1 and R2's ongoing resident assessments listed above were not completed by a registered nurse (RN) per Minnesota Administrative Rule 4659.0140. On November 13, 2024, at 12:28 p.m., clinical nurse supervisor (CNS)-C stated they were going to be the person to complete resident assessments at the facility. The surveyor inquired why assessments were fully completed by LALD/LPN-D. CNS-C stated they were recently hired, and they believed the previous RN and LALD/LPN-D completed previous resident assessments. CNS-C stated they believed a licensed practical nurse (LPN) could complete and assessment every other time an assessment an assessment was due. On November 13, 2024, at 1:47 p.m., LALD/LPN-D stated the RN completed the initial nursing assessment or they assisted the RN with completing the initial nursing assessment. LALD/LPN-D stated typically the RN would complete one assessment on a resident and then they would complete the next resident assessment. The surveyor reviewed the rule 4659.0140 with LALD/LPN-D. LALD/LPN-D	01620			

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01620	Continued From page 39 stated they completed resident assessment every other time because during the last assisted living survey they were told it was an acceptable practice. The licensee's undated Nursing Assessment and Reassessment of Residents policy indicated a comprehensive assessment was completed by a registered nurse pre-admission, within 14 days after the start of service, with change of condition, and at least every 90 days. 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	01650			

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01650	Continued From page 40 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 by: Based on observation, interview, and record review, the licensee failed to ensure the service plan included all required content for two of two residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: R1 R1 admitted to the licensee on June 8, 2020, under the licensee's former comprehensive license and began receiving assisted living services on August 1, 2021. R1's diagnoses included schizophrenia and polysubstance abuse. R1's Planned Services signed October 4, 2024, indicated R1 received assistance with activities,	01650			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 38164	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER SECOND HORIZON LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 7609 MODERN ROAD BROOKLYN PARK, MN 55428		
(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 41 verbal reminders to bathe, grooming, housekeeping, laundry, behavior management, socialization, medication administration, and safety checks. R2 R2 admitted to the licensee on June 24, 2024, and began receiving assisted living services. R2's diagnoses included anxiety, hypertension, mild intellectual disability, seizure disorder, and bipolar (a mental illness characterized by extreme mood swings). R2's Planned Services signed June 25, 2024, indicated R2 received assistance with behavior management, safety checks, socialization, medication management, housekeeping, bathing reminders, grooming, and laundry. On November 12, 2024, at 12:45 p.m., the surveyor observed unlicensed personnel (ULP)-B administer oral medication to R2. R1 and R2's service plan lacked the following required content: - the identification of staff or categories of staff who will provide the services. On November 13, 2024, at 12:30 p.m., clinical nurse supervisor (CNS)-C stated the service plan was a reflection of the resident assessment. CNS-C stated they made sure the assessment matched the planned services however, licensed assisted living director/licensed practical nurse (LALD/LPN)-D completed resident service plans. On November 13, 2024, at 1:53 p.m., LALD/LPN-D stated they attempted to work with RTasks (a software documenting company) to	01650			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 38164	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER SECOND HORIZON LIVING LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 7609 MODERN ROAD BROOKLYN PARK, MN 55428			
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01650	Continued From page 42 create a service plan template however, RTasks's service plan was "in the works" and they had not created a service plan template. LALD/LPN-D stated because RTasks did not have a service plan template they continued to use their older forms which included the contract and a planned service list for residents to sign for the service plan. LALD/LPN-D did not realize it lacked the required content listed above. The licensee's undated Service Plan policy indicated the service plan would include the staff or categories of staff that would provide the services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650			
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to discard expired medication for one of two residents (R1) who received medication administration. This practice resulted in a level two violation (a violation that did not harm a resident's health or	01890			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 38164	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER SECOND HORIZON LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 7609 MODERN ROAD BROOKLYN PARK, MN 55428		
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01890	Continued From page 43 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On November 12, 2024, at approximately 8:38 a.m., the surveyor observed the medication file cabinet with unlicensed personnel (ULP)-B and observed the following expired medications: - R1's gabapentin 300 mg with an expiration date of January 5, 2024. ULP-B stated if they noticed an expired medication they would update the nurse and the nurse would figure out what to do with the medication. On November 12, 2024, at 12:16 p.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-D stated the registered nurse (RN) reviewed the medications within the file cabinet every week or every other week. LALD/LPN-D stated they must have missed removing the medication from the medication file cabinet. On November 13, 2024, at 12:31 p.m., clinical nurse supervisor (CNS)-C stated they reviewed the medication file cabinet one time per month. CNS-C stated medication disposition was completed by them with LALD/LPN-D by dropping off the medication at a pharmacy and documenting the drug disposition. CNS-C stated did not know why the expired medication was still in the medication file cabinet.	01890			

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER SECOND HORIZON LIVING LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 7609 MODERN ROAD BROOKLYN PARK, MN 55428			
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01890	Continued From page 44 The licensee's undated Medication Disposition or Disposal policy indicated discontinued or unused drugs would be destroyed within one month or less of the time they are discontinued or the day of death or discharge of the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890			



Minnesota Department of Health

3333 Division St #212
St. Cloud
320 223-7300

Type: Full
Date: 11/12/24
Time: 11:30:00
Report: 1051241173

Food and Beverage Establishment Inspection Report

Page 1

Location:

Second Horizon Living Llc
7609 Modern Road
Brooklyn Park, MN55428
Hennepin County, 27

Establishment Info:

ID #: 0037857
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6124537783
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.

2-100 Supervision

2-102.12DMN

MN Rule 4626.0033D Post the certified food protection manager certificate.

AT TIME OF INSPECTION, THERE IS NO CURRENT CFPM POSTED.

Comply By: 11/14/24

Food and Equipment Temperatures

Process/Item: Upright Cooler

Temperature: 38 Degrees Fahrenheit - Location: MILK

Violation Issued: No

Process/Item: Cooking

Temperature: 170 Degrees Fahrenheit - Location: CHICKEN CHOW MEIN

Violation Issued: No

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

MET WITH NURSE EVALUATOR, ASHLEY CREWS.

DISCUSSED THE FOLLOWING WITH THE ALF DIRECTOR, YVONNE:

EMPLOYEE ILLNESS LOG

HANDWASHING & GLOVE USE

VOMIT CLEAN-UP PROCEDURE

CERTIFIED FOOD PROTECTION MANAGER

Type: Full
Date: 11/12/24
Time: 11:30:00
Report: 1051241173
Second Horizon Living Llc

Food and Beverage Establishment Inspection Report

Page 2

THE KITCHEN HAS GRANITE COUNTERTOPS WITH HOLLOW BASES, MDF WOODEN CABINETS, SMOOTH TEXTURE CEILING, AND A NSF 184 DISHWASHER.

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 1051241173 of 11/12/24.

Certified Food Protection Manager Laura Kaine

Certification Number: FM109050 Expires: 12/06/24

Inspection report reviewed with person in charge and emailed.

Signed: _____

Yvonne Fergunson
ALF Director

Signed: 

Kai Yang
Public Health Sanitarian 1
St. Cloud
320 640-3532
Kai.Yang@state.mn.us