Electronically Delivered

April 11, 2025

Licensee
Adna Homes LLC
7733 Abbott Avenue North
Brooklyn Park, MN 55443

RE: Project Number(s) SL35731016

Dear Licensee:

On March 14, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the January 21, 2025, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

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

HHH

Electronically Delivered

February 28, 2025

Licensee
Adna Homes LLC
7733 Abbott Avenue North
Brooklyn Park, MN 55443

RE: Project Number(s) SL35731016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on January 23, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

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

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

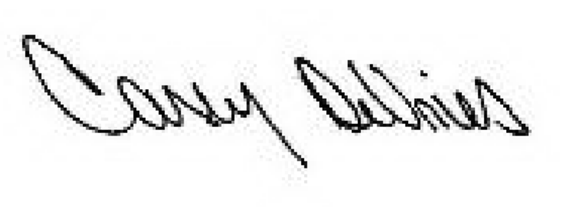
the website listed above.

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,



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

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35731	A. BUILDING: _____ B. WING _____	01/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADNA HOMES LLC	7733 ABBOTT AVENUE NORTH BROOKLYN PARK, MN 55443

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL35731016-0 On January 21, 2025, through January 23, 2025, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were four residents, all of whom received services under the Assisted Living license. An immediate order for correction was issued on January 21, 2025 for tag identification 1290. During the survey, the licensee took action to mitigate the immediate risk. However, noncompliance remained, and the scope and level remain unchanged.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that:	0 470		

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

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0 470	Continued From page 2 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 January 21, 2025, at 12:15 p.m., the surveyor observed two postings of employee schedules dated August 1, 2022, and January 23, 2023, posted on the wall in the living room on the upper level. The licensee's posted employee schedule was not up to date. On January 21, 2025, at approximately 12:20 p.m., unlicensed personal (ULP)-F stated they did not know why they did not have the current staffing schedule posted. On January 22, 2025, at 10:02 a.m., clinical nurse supervisor (CNS)-C stated they were aware that the staffing schedule was not posted. CNS-C stated the housing manager, who was no longer working at the licensee, used to post the schedule every week. The licensee's Staffing policy dated July 31, 2021, indicated: "4. Residents are provided with a means to request assistance for health and safety needs 24 hours/day 7 days/week; during night shifts, the home health aide will respond to resident requests for assistance as soon as possible. 5. A daily staffing schedule is prepared by the clinical nurse supervisor and addresses: -Home health aide work schedules for each home health aide showing all work shifts with days/hours worked -The home health aide's resident assignments or work location".	0 470		

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0 470	Continued From page 3 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food 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;	0 480		

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0 480	Continued From page 4 (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. 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:	0 480		

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0 480	Continued From page 5 Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated January 21, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance.	0 480		
0 630 SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; 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 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	0 630		

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0 630	Continued From page 6 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: R1 R1 was admitted to the licensee on December 12, 2022, with diagnoses which included moderate intellectual disabilities, overweight, and epilepsy. R1's IAPP dated May 17, 2024, indicated R1 was at risk to abuse other vulnerable adults and at risk for abuse and other vulnerabilities related to current placement. R1's IAPP did not include the required statements of the specific measures to be taken to minimize the risk of abuse to that person. R2 R2 was admitted to the licensee on October 31, 2021, with diagnoses which included attention-deficit/hyperactivity disorder (ADHD), bipolar disorder, traumatic brain injury, antisocial personality disorder, severe anxiety, major depression, hypertension, hypothyroidism, and hyperlipidemia. R2's IAPP dated May 18, 2024, indicated R2 was at risk to abuse other vulnerable adults and at risk for abuse and other vulnerabilities related to current placement. R2's IAPP did not include the required statements of the specific measures to be taken to minimize the risk of abuse to that person. On January 22, 2025, at 2:00 p.m., clinical nurse supervisor (CNS)-C stated they had another IAPP	0 630		

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0 630	Continued From page 7 completed on a word document with the required content, but CNS-C was unable to find the document in the resident's chart. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
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 infomation: (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	0 650		

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0 650	Continued From page 8 review, the licensee failed to ensure employee records included all required content for three of three employees (unlicensed personnel (ULP)-A, ULP-B, clinical nurse supervisor (CNS)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-A ULP-A was hired April 17, 2021, to provide direct care services to residents. ULP-B ULP-B was hired February 27, 2022, to provide direct care services to residents. On January 23, 2025, at 8:45 a.m., the surveyor observed ULP-B perform medication administration to R3. CNS-C CNS-C was hired on December 6, 2020, to provide direct care services to residents and to provide direct supervision to staff. CNS-C's Position Description-Clinical Supervisor signed and dated on July 29, 2021, indicated CNS-C reported to the director and was responsible for conducting annual performance evaluations of direct care staff. CNS-C's employee record included Performance	0 650		

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0 650	Continued From page 9 Evaluation signed and dated on December 6, 2021. ULP-A, ULP-B, and CNS-C's employee records lacked performance reviews completed annually. On January 22, 2025, at 9:57 a.m., CNS-C stated, "I evaluate myself and put in the chart, since I am the supervisor." CNS-C also stated they completed performance evaluation for all employees around May. CNS-C stated they did not know why they were not in the employees' folders. The licensee's performance evaluation policy dated July 31, 2021, indicated, "Policy Statement: All paid employees, individual contractors and regularly scheduled volunteers providing assisted living services will participate in an annual performance evaluation. The purpose of the evaluation is to measure job performance and assist the employee and supervisor to build on the strengths of the employee and identify those areas needing improvement. Procedure: 1. A formal performance evaluation will be conducted for all staff providing assisted living services at least annually. 2. The staff member's supervisor will complete the evaluation using a standard tool based on the employee's job description. 3. The performance evaluation will address any of the following: a. Areas of improvement needed b. The performance evaluation will include any additional education or training needs for the staff member 4. For unlicensed staff, information from the supervisory visits will be included in the evaluation process. At the discretion of the	0 650		

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0 650	Continued From page 10 supervisor, an onsite supervisory visit may be conducted as part of the evaluation process. 5. Documentation of the annual performance evaluation will be maintained in the personnel file.*" No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule.	0 680		

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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
0 680	Continued From page 11 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain an 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's Emergency Preparedness Plan reviewed on October 22, 2021, lacked evidence of the following required contents: - policies and procedures for volunteers; - roles under a waiver declared by secretary; - quarterly review of the missing resident plan; - annual review of the EP policies and procedures; - subsistence needs for staff and patients ; - procedures for tracking of staff and patients; - polices and procedures for medical documents; and - sharing information on occupancy/needs. On January 23, 2025, at approximately 10:50 a.m., via telephone, licensed assisted living director (LALD)-D stated the EPP was reviewed every three months, and the missing resident plan was reviewed on a yearly basis. LALD-D	0 680		

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	35731	A. BUILDING: _____ B. WING _____	01/23/2025

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0 680	Continued From page 12 further stated they could not recall why the EPP, and the missing resident policies were not documented as reviewed. LALD-D also stated they could not recall why the above-mentioned missing items were missing from the EPP. The licensee's Emergency Preparedness policy dated July 31, 2021, indicated the EPP would be reviewed/updated at least annually. The licensee's Missing Resident policy dated July 31, 2021, indicated the missing resident procedure would be reviewed by the director ant the clinical nurse supervisor at least quarterly and changes to the plan will be documented. Minnesota Administrative Rule 4659.0110, Subpart 4 dated August 11, 2021, indicated the assisted living director and clinical nurse supervisor must review the missing person plan at least quarterly and document any changes to the plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 775 SS=D	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with the Minnesota State Fire	0 775		

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0 775	Continued From page 13 Code in Minnesota Rules, chapter 7511. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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 January 21, 2025, from 10:00 a.m. to 11:00 a.m., the surveyor toured the facility with unlicensed personnel (ULP)-E. The surveyor made the following observations of non-compliance with Minnesota Fire Code provisions: There was a 12-inch by 15-inch piece of the fire-resistant drywall missing from the wall separating the garage from the assisted living. The fire-resistant drywall on the garage side of the wall separating the garage from the assisted living is required to be maintained and sealed as installed and approved at the time of construction in accordance with current Minnesota Fire Code. On January 22, 2025, at 1:30 p.m., ULP-E stated they did not realize a piece of the drywall was missing. TIME PERIOD FOR CORRECTION: Seven (7) days	0 775		

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0 780	Continued From page 14	0 780		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that functioned and were interconnected so that the actuation of one alarm caused all alarms in the dwelling unit to actuate. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	0 780		

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0 780	Continued From page 15 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 January 21, 2025, from 10:00 a.m. to 11:00 a.m., the surveyor toured the facility with unlicensed personnel (ULP)-E. The surveyor asked ULP-E to initiate a test of the smoke alarms throughout the home. Upon testing, it was found that the smoke alarm in the upstairs hallway outside resident sleeping rooms 1, 2, and 3 was not interconnected with the rest of the smoke alarms in the facility. This deficient condition was visually verified at the time of discovery by ULP-E accompanying on the tour. On January 21, 2025, at 1:30 p.m., ULP-E stated they did not realize the hallway smoke alarm was not interconnected with the rest. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780		
0 800 SS=D	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and	0 800		

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0 800	Continued From page 16 repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment in a continuous state of good repair and operation. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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 January 21, 2025, from 10:00 a.m. to 11:00 a.m., the surveyor toured the facility with unlicensed personnel (ULP)-E. The surveyor observed the following: - The exterior brick sills on each of the columns and the decorative wainscot along the front of the building adjacent to the garage door was broken or missing in multiple locations. The mortar was pulled away from the bricks in multiple locations and was falling out of the wall. Exterior cladding shall be maintaned to prevent water intrusion and potential structural damage or mold growth caused by water intrusion. - The egress window in bedroom 3 was difficult to	0 800		

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0 800	Continued From page 17 open. ULP-E pulled on the sliding window pane multiple times in an attempt to open the window completely. Egress windows must be maintained in proper working order to ensure safe egress during the event of a fire or similar emergency. ULP-E stated they did not realize the window in bedroom 3 was difficult to open. These deficient conditions were visually verified at the time of discovery by ULP-E accompanying on the tour. On January 21, 2025, at 1:30 p.m., ULP-E stated they didn't realize the damage to the exterior brick and mortar was so extensive. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 800		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (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.	0 810		

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0 810	Continued From page 18 (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content, provide the required training. 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). The findings include: On January 22, 2025, unlicensed personnel (ULP)-G provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the	0 810		

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0 810	Continued From page 19 facility. FIRE SAFETY AND EVACUATION PLAN: The licensee's FSEP, titled "Fire Safety", failed to include the following: The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The provided FSEP was from a third-party provider and had not been updated to the specific facility. The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. The FSEP included standard resident evacuation procedures but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan included instructions to evacuate residents but did not include any procedures for assisting residents during evacuation nor did it include instructions for staff to follow in case of relocation. On January 22, 2025, at 1:30 p.m., ULP-G stated they didn't understand that the third-party policy they were using was not correct. ULP-G stated they would work on bringing them into compliance. The policy reviewed was an unedited policy from a third-party provider that was not specific to the facility. TRAINING:	0 810		

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0 810	Continued From page 20 The licensee failed to provide evacuation training to residents at least once per year. ULP-G lacked documentation showing any training was offered or training was scheduled for a future date for residents on the fire safety and evacuation plan. The licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. ULP-G lacked documentation showing any training was offered or training was scheduled for a future date for employees on the fire safety and evacuation plan. On January 22, 2025, at 1:30 p.m., ULP-G stated they were training their employees and residents, but couldn't find the documentation. ULP-G stated they would find the documentation and email the surveyor by the end of the day on January 22, 2025. No email was received. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
0 910 SS=B	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: (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.	0 910		

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0 910	Continued From page 21 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 three of four residents (R1, R2, R4). 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 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: R1 R1 was admitted to the licensee on December 12, 2022, and received assisted living services. R1's Assisting Living Contract signed on November 21, 2022, lacked the following required content: - in a conspicuous place and manner on the contract the Health Facility Identification number (HFID#) of the licensee. R2 R2 was admitted to the licensee on October 31, 2021, and received assisted living services. R2's Assisting Living Contract signed on October 31, 2021, lacked the following required content: - in a conspicuous place and manner on the contract the HFID# of the licensee. R4	0 910		

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0 910	Continued From page 22 R4 was admitted to the licensee on November 23, 2020, and received assisted living services. R4's Assisting Living Contract signed on April 7, 2022, lacked the following required content: - in a conspicuous place and manner on the contract the HFID# of the licensee. On January 23, 2025, at 10:37 a.m., licensed assisted living director (LALD)-D stated it might be an oversight that they did not have HFID# in the contract and stated, "I will look into it." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 910		
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the licensee's liability for health, safety, or personal property of a resident for four of four residents (R1, R2, R3, R4).	0 970		

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0 970	Continued From page 23 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: R1 R1's Assisting Living Contract was signed on November 21, 2022. R1's Assisted Living Contract, page 11, titled Miscellaneous Provisions, indicated, "1. Insurance Liability and Release. The resident shall maintain at all times his or her own health, personal property, liability, automobile (if applicable), and other insurance coverages and shall provide evidence of same by copies of binders or policies provided to [licensee's name] upon request. The resident acknowledges that [licensee's name] is not an insurer of the resident's person or property. The resident agrees that [licensee's name] will not be liable to the resident for any personal injury or property damage (including, without limitation, damage to, or loss or theft of, automobiles or personal property of resident) suffered by the resident ... unless and to the extent that the injury or damage is caused by the negligence of [licensee's name] or its employees or agents. The resident hereby releases [licensee's name] from liability for any personal injury or property damage suffered by the resident ... unless caused by the negligence of [licensee's name] or its employees or agents." R2	0 970		

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0 970	Continued From page 24 R2's assisted living contract was signed on October 31, 2021. R2's Assisted Living Contract, page 13, titled Miscellaneous Provisions, indicated, "1. Insurance Liability and Release. The resident shall maintain at all times his or her own health, personal property, liability, automobile (if applicable), and other insurance coverages and shall provide evidence of same by copies of binders or policies provided to [licensee's name] upon request. The resident acknowledges that [licensee's name] is not an insurer of the resident's person or property. The resident agrees that [licensee's name] will not be liable to the resident for any personal injury or property damage (including, without limitation, damage to, or loss or theft of, automobiles or personal property of resident) suffered by the resident ... unless and to the extent that the injury or damage is caused by the negligence of [licensee's name] or its employees or agents. The resident hereby releases [licensee's name] from liability for any personal injury or property damage suffered by the resident ... unless caused by the negligence of [licensee's name] or its employees or agents." R3 R3's Assisting Living Contract was signed on August 1, 2021. R3's Assisted Living Contract, page 11, titled Miscellaneous Provisions, indicated, "1. Insurance Liability and Release. The resident shall maintain at all times his or her own health, personal property, liability, automobile (if applicable), and other insurance coverages and shall provide evidence of same by copies of binders or policies provided to [licensee's name] upon request. The resident acknowledges that	0 970		

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0 970	Continued From page 25 [licensee's name] is not an insurer of the resident's person or property. The resident agrees that [licensee's name] will not be liable to the resident for any personal injury or property damage (including, without limitation, damage to, or loss or theft of, automobiles or personal property of resident) suffered by the resident ... unless and to the extent that the injury or damage is caused by the negligence of [licensee's name] or its employees or agents. The resident hereby releases [licensee's name] from liability for any personal injury or property damage suffered by the resident ... unless caused by the negligence of [licensee's name] or its employees or agents." R4 R4's Assisting Living Contract was signed on April 7, 2022. R4's Assisted Living Contract, page 12, titled Miscellaneous Provisions, indicated, "1. Insurance Liability and Release. The resident shall maintain at all times his or her own health, personal property, liability, automobile (if applicable), and other insurance coverages and shall provide evidence of same by copies of binders or policies provided to [licensee's name] upon request. The resident acknowledges that [licensee's name] is not an insurer of the resident's person or property. The resident agrees that [licensee's name] will not be liable to the resident for any personal injury or property damage (including, without limitation, damage to, or loss or theft of, automobiles or personal property of resident) suffered by the resident ... unless and to the extent that the injury or damage is caused by the negligence of [licensee's name] or its employees or agents. The resident hereby releases [licensee's name] from liability for any personal injury or property damage suffered by	0 970		

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	35731	A. BUILDING: _____ B. WING _____	01/23/2025

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0 970	Continued From page 26 the resident ... unless caused by the negligence of [licensee's name] or its employees or agents." On January 23, 2025, at 10:42 a.m., licensed assisted living director (LALD)-D stated they did not know why the assisted living contract contained waivers of liability; the contract forms came from the consultants. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
01290 SS=H	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. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a background study (BGS) was current and eligible on NETStudy 2.0	01290	During the survey, the licensee took action to mitigate the immediate risk. However, noncompliance remained, and the scope	

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01290	Continued From page 27 (web-based system for submitting background study requests to the Department of Human Services (DHS)) for two of seven employees (unlicensed personnel (ULP)-A, clinical nurse supervisor CNS-C). 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 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: ULP-A ULP- A was hired on April 17, 2021, to provide direct cares and services to residents. The licensee's work schedule for January 20, 2025, through January 26, 2025, indicated ULP-A was scheduled to work morning-shifts (7:00 a.m. to 3:30 p.m.) for the following dates: January 24, and 26, 2025, and night-shifts (11:00 p.m. to 7:00 a.m.) for the following dates: January 22 and 25, 2025. ULP-A was scheduled to work independently without direct supervision. ULP-A's employee record included a background study clearance letter dated April 2, 2021, which was run under the licensee's previous health facility identification (HFID) number 35300. The licensee's NETStudy 2.0 BGS roster for HFID 35731 printed on January 21, 2025, did not include ULP-A in the list of employes affiliated.	01290	and level remain unchanged.	

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01290	Continued From page 28 The licensee lacked evidence the licensee submitted a background stud for ULP-A under the current HFID. CNS-C CNS-C was hired on December 6, 2020, to provide nursing care to residents and oversight to ULPs. CNS-C's employee record included a background study clearance letter dated November 20, 2020, under the licensee's previous HFID number 35300. CNS-C's employee record also included a copy Minnesota board of nursing licensee information which indicated active RN licensee issued on December 29, 2016. The licensee's BGS roster printed from NETStudy 2.0 on January 21, 2025, indicated CNS-C was affiliated to the licensee's HFID 35731. However, the "eligible covid 19 study" expired on December 31, 2022. The licensee lacked evidence the licensee submitted a background study for CNS-C after the covid 19 eligible status expired. On January 21, 2025, at 11:45 a.m., via telephone, licensed assisted living director (LALD)-D stated HFID 35300 was a previous HFID for a comprehensive license. LALD-D stated HFID 35300 was switched to the current HFID 35731, therefore, was no longer accessible to be viewed in NETStudy 2.0. On January 21, 2025, at 1:05 p.m., via telephone, LALD-D stated they could not recall if the above-mentioned employees had the BGS. LALD-D stated they were traveling, and they would look into it when they got back. On January 21, 2025, at 1:15 p.m., via telephone,	01290		

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01290	Continued From page 29 administrator (A)-F stated the background study for all employees got transferred automatically when they switched to the new HFID and stated they did not know why ULP-A's BGS was not transferred. On January 21, 2025, at 2:23 p.m., CNS-C stated ULP-A worked both shifts independently without supervision. The licensee's Recruitment and Hiring Policy dated July 31, 2021 indicated, "The Criminal Background Check will be submitted to Minnesota Department of Human Services (DHS) following the step-by-step procedure established by DHS: i. The director or designee is responsible for initiating the criminal background study for new employees ii. NetStudy 2.0 (or current version) will be used for the background check iii. The employee will be directed to locations established by DHS to obtain fingerprint scans iv. Employees will be instructed that photographic identification will be required v. Employees/study subjects may enter their own background study demographic information using the facility identification code provided vi. Results of the background study will be maintained in the employee's personnel file*" On September 9, 2024, the Minnesota Department of Human Services website indicated the following: - Emergency studies completed during the COVID-19 pandemic were no longer valid. - Individuals who only had an emergency study must have a fully compliant, fingerprint-based background study. Roster maintenance	01290		

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01290	Continued From page 30 - Individuals with a completed emergency study will remain on the entity's roster unless the entity removes the individual. Entities should remove individuals with emergency studies that are no longer affiliated; - If the individual should no longer be affiliated and has a new fully compliant background study, the entity should wait until the individual is separated and then remove both the emergency study and fully compliant study from their roster at the same time; - All entities are responsible for maintaining their rosters regularly and removing study subjects from their roster when they are no longer affiliated; and - Entities are responsible for identifying who needs to submit a new background study. For help identifying which study subjects still have an emergency study and need a fully compliant study, entities should refer to the instructional guide, "Identifying Emergency Studies" in the help section of NETStudy 2.0. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	01290		
01470 SS=E	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the	01470		

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01470	Continued From page 31 maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the staff member will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology	01470		

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01470	Continued From page 32 that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure staff providing services completed an orientation to assisted living facility licensing requirements and regulations before providing services for two of three employees (unlicensed personnel (ULP)-A, clinical nurse supervisor (CNS)-C). 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 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: ULP-A ULP-A was hired April 17, 2021, to provide direct care services to residents. CNS-C CNS-C was hired on December 6, 2020, to provide direct care services to residents and to provide direct supervision to staff.	01470		

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01470	Continued From page 33 ULP-A and CNS-C's employee records lacked evidence of orientation to assisted living regulations for the following topic: - review of provider's policies and procedures On January 22, 2025, at 9:40 a.m., via telephone, administrator (A)-F stated they should have the policy and procedure training done for all employees and stated, "I am shocked that we do not have it." The license's Staff Orientation and Education policy dated July 31, 2021, indicated all staff providing assisted living services will be prepared to provide safe, effective services to all residents through a thorough orientation and education program pertinent to the needs of the residents. Orientation topics will include, but not be limited to, the following: a. Overview of Minnesota Assisted Living Statute 144G and Minnesota Rules Chapter 4659; b. Review of the employee's job description and responsibilities; c. Introduction to and review of the organization's policies and procedures related to the provision of assisted living services by the individual staff person; d. Handling of emergencies and the use of emergency services; e. Compliance with Minnesota's Vulnerable Adult (Sections 626.556 and 5572); f. The Assisted Living Bill of Rights and the employee's responsibilities to ensure the exercise and protection of those rights; g. The principles of person-centered planning and service delivery and how they apply to direct support services provided by staff; h. Grievance Policy/Process, including reports to the Office of Health Facility Complaints; i. Consumer advocacy services;	01470		

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01470	Continued From page 34 j. The types of assisted living services the employee will be providing based on the Uniform Checklist Disclosure of Services and the organization's category of licensure; and k. The organizational chart and roles of staff within the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
01500 SS=E	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with	01500		

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01500	Continued From page 35 residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an employee received at least eight hours of annual training for each 12 months of employment for two of three employees (unlicensed personnel (ULP)-A, clinical nurse supervisor (CNS)-C).	01500		

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01500	Continued From page 36 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: ULP-A ULP-A was hired April 17, 2021, to provide direct care services to residents. CNS-C CNS-C was hired on December 6, 2020, to provide direct care services to residents and to provide direct supervision to staff. ULP-A and CNS-C's employee records lacked the following annual training topics completed every 12 months: - review of provider policies and procedures; and - principles of person-centered planning/service delivery. On January 22, 2025, at 9:40 a.m., via telephone, administrator (A)-F stated they assigned training modules to employees. A-F stated ULP-A and CNS-C's principles of person-centered planning/service delivery was expired, and they forgot to re-assign it to both employes. (A)-F stated they should have the policy and procedure training done for all employees and stated, "I am shocked that we do not have it." The license's Staff Orientation and Education	01500		

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01500	Continued From page 37 policy dated July 31, 2021, indicated All staff providing assisted living services will complete at least eight (8) hours of education for every twelve (12) months of employment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		
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;	01530		

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01530	Continued From page 38 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure one of three employees (unlicensed personnel (ULP)-A) received at least eight hours of initial dementia care training within 160 working hours of their employment start date. 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-A was hired April 17, 2021, to provide direct care services to residents. ULP-A's employee record included an Educare (online training platform) training document which indicated ULP-A had 0.75 hours of dementia training completed on October 17, 2021, 2.5 hours of dementia training completed on September 18, 2023, through September 23, 2023, and 2.5 hours of dementia training completed on November 1, 2024, for a total 5.75 hours which was 2.25 hours short of the required eight hours of dementia training required to be completed within 160 working hours of the ULP's employment start date. The Licensee's work schedule dated January 2025 indicated ULP-A was scheduled to work 42 hours every week for four weeks, for a total of	01530		

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01530	Continued From page 39 168 hours in a month. On January 22, 2025, at 9:40 a.m., via telephone, administrator (A)-F stated they assigned training modules to employees. On January 22, 2025, at 9:47 a.m., via telephone, A-F stated Educare assigned all of the required initial trainings to employees, and it was not something they assign. A-F further stated they did not why ULP-A was missing dementia training hours. The licensee's Dementia Education policy dated July 31, 2021, indicated direct care employees must have at least eight hours of initial dementia training within 160 working hours of the employment start date. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
01640 SS=F	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35731	A. BUILDING: _____ B. WING _____	01/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADNA HOMES LLC	7733 ABBOTT AVENUE NORTH BROOKLYN PARK, MN 55443

(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
01640	Continued From page 40 Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the current service plan included a signature or other authentication by the resident or resident's designated representative and the licensee to document agreement on the services to be provided for two of three residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: R1 R1 was admitted to the licensee on December 12, 2022, with diagnoses which included moderate intellectual disabilities, overweight, and epilepsy. R1's unsigned service plan dated May 28, 2024,	01640		

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	35731	A. BUILDING: _____ B. WING _____	01/23/2025

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01640	Continued From page 41 indicated R1 received assistance with dressing, grooming, bathing reminder, escort/mobility assistance, transportation assistance, shopping assistance, manage behaviors, housekeeping, linen change, and medication administration. R2 R2 was admitted to the licensee on October 31, 2021, with diagnoses which included attention-deficit/hyperactivity disorder (ADHD), bipolar disorder, traumatic brain injury, antisocial personality disorder, severe anxiety, major depression, hypertension, hypothyroidism, and hyperlipidemia. R2's service plan dated January 1, 2022, indicated R2 received assistance with record blood glucose and medication administration. R2's service plan was signed by clinical nurse supervisor (CNS)-C, but lacked the signature of the resident or resident representative. On January 22, 2025, at 11:25 a.m., CNS-C stated they must have forgotten to sign R1's service plan. CNS-C stated, "I can sign it now." On January 22, 2025, at 1:34 p.m., CNS-C stated they sign the service plan on admission. CNS-C stated their understanding was that the CNS was the only person who needed to sign the service plan, "I sign the service plan that is it." The licensee's undated Service Plan policy indicated the initial service plan, and any revisions are signed by the licensee's representative and the resident or resident's representative, indicating agreement with the services to be provided. No further information was provided.	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35731	A. BUILDING: _____ B. WING _____	01/23/2025

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01640	Continued From page 42 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01790 SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be	01790		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35731	A. BUILDING: _____ B. WING _____	01/23/2025

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01790	Continued From page 43 labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) documented training and/or competencies for two of two unlicensed personnel ((ULP)-A, ULP-B) who would provide medications for residents with unplanned time away from home when a licensed nurse was not available. 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	01790		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01790	Continued From page 44 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: ULP-A ULP-A was hired April 17, 2021, to provide direct care services to residents. ULP-B ULP-B was hired February 27, 2022, to provide direct care services to residents. ULP-A and ULP-B's employee records lacked evidence of training and competency in preparing medications for unplanned times away when the licensed nurse is not available. On January 23, 2025, at 10:00 a.m., ULP-B stated they did take medications out of the bubble pack and put medication in a little bag and gave it to residents when residents had to go on a leave of absence unexpectedly. On January 23, 2025, at 11:06 a.m., clinical nurse supervisor (CNS-C) stated they did the medication set up and ULPs give the box to residents who were going out of the facility. ULPs did the medication preparation under their direction and there was no specific training on preparing medications for unplanned times away; it was part of the medication administration training. There was no specific instruction written by the RN for unplanned times away medication preparation. No further information was provided.	01790		

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01790	Continued From page 45 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01790		

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

Type: Full
Date: *01/21/25*
Time: 10:48:05
Report: 1050251017

Food and Beverage Establishment Inspection Report

Location:
Adna Homes Llc
7733 Abbott Avenue North
Brooklyn Park, MN55443
Hennepin County, 27

Establishment Info:
ID #: 0039316
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7632086626
ID #:

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

The following orders were issued during this inspection.

3-300B Protection from Contamination: cross-contamination, eggs

3-302.11A(1) ***** Priority 1 *****

MN Rule 4626.0235A(1) Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.

OBSERVED EGGS STORED IMPROPERLY ON TOP SHELF ABOVE RTE FOODS. DISCUSSED STORING AT THE BOTTOM TO AVOID POTENTIAL CONTAMINATION. COMPLY WITH RULE ABOVE.

Comply By: 01/21/25

4-200 Equipment Design and Construction

4-202.11 ***** Priority 2 *****

MN Rule 4626.0515 Discontinue use of multi-use food-contact surfaces that are not smooth, free of breaks, open seams, cracks, chips, pits and other imperfections and that are not accessible for cleaning or inspection.

OBSERVED SEVERAL CUTTING BOARDS THAT WHERE HEAVILY DAMAGED. DISCUSSED DISCARDING DAMAGED BOARDS TO REPLACE WITH NEW. COMPLY WITH RULE ABOVE.

Comply By: 01/21/25

4-300 Equipment Numbers and Capacities

4-302.12B ***** Priority 2 *****

MN Rule 4626.0705B Provide a readily accessible food temperature measuring device with a small diameter probe to measure the temperature in thin foods such as meat patties and fish fillets.

FACILITY DOES NOT HAVE THIN PROBE THERMOMETER TO PROBE MEATS ON SITE DURING INSPECTION. SECURE THIN PROBE THERMOMETER TO UTILIZE WHILE COOKING FOOD ITEMS. COMPLY WITH RULE ABOVE.

Comply By: 01/21/25

Type: Full
Date: *01/21/25*
Time: 10:48:05
Report: 1050251017
Adna Homes Llc

Food and Beverage Establishment Inspection Report

2-100 Supervision

2-102.12AMN

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

FACILITY DOES NOT HAVE CURRENT MN CFPM CERTIFICATE. FACILITY CURRENTLY HAS FOOD PROTECTION MANAGER THROUGH LEARN2SERVE WITH EXP. 4/22/22. PROVIDED INSTRUCTIONS VIA EMAIL. COMPLY WITH RULE ABOVE.

Comply By: 01/21/25

Food and Equipment Temperatures

Process/Item: Cold Holding/Milk
Temperature: 49F Degrees Fahrenheit - Location: Reach-In Cooler
Violation Issued: No

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

Unannounced inspection completed by MDH Andrew Spaulding and Samira in absence of Food Director on 1/21/25.

This establishment has a residential kitchen. Food must be prepared for same day service only. The kitchen has wood cabinets with a hollow base and laminate flooring. All found to be in good condition. No pests issues seen on site during inspection.

Facility had four residents on site at time of inspection. Meals are prepared on site.

Discussed the following:
-Employee illness policy and logging requirements
-Hand Washing
-Diswasher
-Glove-use and bare hand contact
-Food storage and preventing cross contamination
-Date marking
-Vomit clean up procedures
-Restrictions concerning serving a highly susceptible population

Type: Full
Date: *01/21/25*
Time: 10:48:05
Report: 1050251017
Adna Homes Llc

Food and Beverage Establishment Inspection Report

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Minnesota Department Of Health inspection report number 1050251017 of 01/21/25.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /

Inspection report reviewed with person in charge and emailed.

Signed:_____

Hana Salad
Food Director

Signed:_____

Andrew Spaulding
Public Health Sanitarian 2
FPLS Metro
651-201-5298
andrew.spaulding@state.mn.us