



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

January 10, 2025

Licensee
Merrcy Care Home LLC
1609 Edgewood Avenue South
Saint Louis Park, MN 55426

RE: Project Number(s) SL36116015

Dear Licensee:

On December 24, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the July 10, 2024, survey and October 1, 2024, follow-up 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,

A handwritten signature in black ink that reads 'Casey DeVries'.

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

JMD



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

November 1, 2024

Licensee

Merrcy Care Home LLC

1609 Edgewood Avenue South

Saint Louis Park, MN 55426

RE: Project Number(s) SL36116015

Dear Licensee:

On October 1, 2024, 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 July 10, 2024. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the July 10, 2024 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on July 10, 2024, found not corrected at the time of the October 1, 2024, follow-up survey and/or subject to penalty assessment are as follows:

0650 - Employee Records - 144g.42 Subd. 8

0820 - Fire Protection And Physical Environment - 144g.45 Subd. 2 (g) - \$500.00

1370 - Training And Evaluation Of Unlicensed Personn - 144g.61 Subd. 2 (a)

1380 - Training And Evaluation Of Unlicensed Personn - 144g.61 Subd. 2 (b)

1470 - Content Of Required Orientation - 144g.63 Subd. 2

1530 - Training In Dementia Care Required - 144g.64

1620 - Initial Reviews, Assessments, And Monitoring - 144g.70 Subd. 2 (c-E)

1760 - Documentation Of Administration Of Medication - 144g.71 Subd. 8

1890 - Prescription Drugs - 144g.71 Subd. 20

2320 - Appropriate Care And Services - 144g.91 Subd. 4 (b)

The details of the violations noted at the time of this follow-up survey completed on October 1, 2024 (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 \$500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

Also, at the time of this follow-up survey completed on October 1, 2024, we identified the following violation(s):

1650 - Service Plan, Implementation And Revisions To - 144g.70 Subd. 4 (f)

The details of the violation(s) noted at the time of this follow-up survey are delineated on the attached State Form. Only the ID Prefix Tag in the left hand column without brackets will identify these state correction orders. It is not necessary to develop a plan of correction.

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 Jodi Johnson at 507-344-2730.

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,

A handwritten signature in black ink, appearing to read "Jodi Johnson", with a stylized flourish at the end.

Jodi Johnson, Supervisor
State Evaluation Team
Email: jodi.johnson@state.mn.us
Telephone: 507-344-2730 Fax: 1-866-890-9290

JMD

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36116	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 10/01/2024
NAME OF PROVIDER OR SUPPLIER MERRCY CARE HOME LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1609 EDGEWOOD AVENUE SOUTH SAINT LOUIS PARK, MN 55426		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
{0 000}	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been 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: SL36116015-1 On September 30, 2024, through October 1, 2024, 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 July 10, 2024. At the time of the survey, there were four residents; four 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.		
{0 480} SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	{0 480}			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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{0 480}	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Not reviewed during this survey	{0 480}			
{0 650} SS=D	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:	{0 650}			

Minnesota Department of Health

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{0 650}	Continued From page 2 Based on interview and record review, the licensee failed to ensure employee records included all required content for one of one employee (unlicensed personnel (ULP)-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, 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-C began providing direct care services for the licensee on January 1, 2023. ULP-C's record lacked an annual performance review that identified areas of improvement needed and training needs. On July 9, 2024, at 1:38 p.m. house manager (HM)-A stated ULP-C's record did not include evidence of an annual performance review since hire. During the revisit survey on September 30, 2024, at 12:56 p.m. HM-A stated they had not attempted to conduct an annual performance review for ULP-C since the last survey. The licensee's 4.9 Personnel Records policy dated July 21, 2022, indicated employee records for each person will include documentation of annual performance reviews that identify areas of improvement needed and training needs.	{0 650}			

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{0 650}	Continued From page 3 No further information was provided.	{0 650}			
{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: Not reviewed during this survey	{0 790}			
{0 800} SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Not reviewed during this survey	{0 800}			

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{0 810}	Continued From page 4	{0 810}			
{0 810} SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by:	{0 810}			

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{0 810}	Continued From page 5 Not reviewed during this survey	{0 810}			
{0 820} SS=F	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. 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. This had the potential to directly affect all 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 potential to affect a large portion or all of the residents). Findings include: On a facility tour on July 10, 2024, at	{0 820}			

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{0 820}	Continued From page 6 approximately 10:45 a.m. with the House Manager (HM)-A, it was observed cigarette butts were discarded on the ground outside the front door and garage. The surveyor explained to the House Manager HM-A, that all cigarette butts shall be properly discarded into an approved container and that cigarette smoking should take place in the designated area away from the structure. The deficient conditions were visually verified by the HM-A accompanying on the tour. During the survey revisit on September 30, 2024, at 11:55 a.m. the surveyor observed approximately 20 discarded cigarette butts outside the side door in the back of the house on the grass. HM-A was present during the observation and stated R4 smoked back there and wasn't compliant with utilizing the approved container to discard the cigarette butts.	{0 820}			
{01370} SS=E	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing;	{01370}			

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{01370}	Continued From page 7 (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and competency evaluations were completed as required prior to providing direct care for two of two unlicensed personnel (ULP-F, ULP-G). 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	{01370}			

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{01370}	Continued From page 8 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: During the revisit survey entrance conference on September 30, 2024, at 1:08 p.m. house manager (HM)-A stated the licensee now utilized Educare online training and had assigned staff required trainings that were missing. ULP-F ULP-F was hired to provide direct care services on June 11, 2024. ULP-F's record lacked evidence the following education and/or competencies had been completed prior to providing direct cares: - documentation requirements for all services provided; - basic infection control, including blood-borne pathogens; - maintenance of a clean and safe environment; - training on the prevention of falls for providers working with the elderly or individuals at risk of falls; - basic nutrition, meal preparation, food safety, and assistance with eating; - preparation of modified diets as ordered by a licensed health professional; - communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; - awareness of confidentiality and privacy; - understanding appropriate boundaries between staff and clients and the client's family.	{01370}			

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{01370}	Continued From page 9 ULP-G ULP-G was hired to provide direct care services on July 24, 2024. ULP-G's record lacked evidence the following education and/or competencies had been completed prior to providing direct cares: - documentation requirements for all services provided; - basic infection control, including blood-borne pathogens; - training on the prevention of falls for providers working with the elderly or individuals at risk of falls; - basic nutrition, meal preparation, food safety, and assistance with eating; - preparation of modified diets as ordered by a licensed health professional; - understanding appropriate boundaries between staff and clients and the client's family. On September 30, 2024, HM-A reviewed ULP-F and ULP-G's employee file and stated it did not include evidence the above trainings had been completed. The licensee's Staff Competency policy dated July 21, 2022, indicated: 3. Training and competency evaluations for all unlicensed personnel include the following. a. Documentation requirements for all services provided c. Basic infection control, including blood-borne pathogens d. Maintenance of a clean and safe environment f. Training on the prevention of falls for providers working with the elderly or those at risk of falls. i. Basic nutrition, meal preparation and	{01370}			

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{01370}	Continued From page 10 preparation of modified diets as ordered by a licensed health professional, food safety and assistance with eating. j. Communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preference, cultural background and family k. Awareness of confidentiality and privacy l. Understanding appropriate boundaries between staff, residents and the resident's family No further information was provided.	{01370}			
{01380} SS=E	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency evaluations were completed as required prior to	{01380}			

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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
{01380}	Continued From page 11 providing direct care for two of two unlicensed personnel (ULP-F, ULP-G). 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: During the revisit survey entrance conference on September 30, 2024, at 1:08 p.m. house manager (HM)-A stated the licensee now utilized Educare online training and had assigned staff required trainings that were missing. ULP-F was hired to provide direct care services on June 11, 2024. ULP-F's record lacked evidence the following education and/or competencies had been completed prior to providing direct cares: - observing, reporting, and documenting resident status; - basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; and - recognizing physical, emotional, cognitive, and developmental needs of the client. ULP-G ULP-G was hired to provide direct care services on July 24, 2024.	{01380}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36116	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 10/01/2024
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{01380}	Continued From page 12 ULP-G's record lacked evidence the following education and/or competencies had been completed prior to providing direct cares: - observing, reporting, and documenting resident status; On September 30, 2024, HM-A reviewed ULP-F and ULP-G's employee file and stated it did not include evidence the above trainings had been completed. The licensee's Staff Competency policy dated July 21, 2022, indicated: 4. Home Health Aides (HHA) providing assisted living services and who have not completed a state-approved formal training and competency evaluation program will demonstrate competency through the following process a. Satisfactory completion of an oral or written test on the tasks the HHA will perform. b. Home Health Aides may not work for the licensee until they have successfully passed the written and demonstration competency evaluation, including satisfactory completion of the following i. Observation, reporting and documenting of resident status ii. Basic knowledge of body functioning and changes in body function, injuries or other reportable changes iii. Recognizing physical, emotional, cognitive, and development needs of the resident. No further information was provided.	{01380}			
{01470} SS=E	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following	{01470}			

Minnesota Department of Health

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{01470}	Continued From page 13 topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following	{01470}			

Minnesota Department of Health

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{01470}	Continued From page 14 topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure two of two new unlicensed personnel (ULP-F, ULP-G) received orientation to assisted living facility licensing requirements and regulations before providing services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and 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: During the revisit survey entrance conference on September 30, 2024, at 1:08 p.m. house manager (HM)-A stated the licensee now utilized	{01470}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36116	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 10/01/2024
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{01470}	Continued From page 15 Educare online training and had assigned staff required trainings that were missing. ULP-F ULP-F was hired on June 11, 2024, to provide direct care services for the licensee. ULP-F's employee record lacked evidence of receiving orientation to assisted living to include the following required content: - overview of assisted living statutes; - review of provider's policies and procedures; - handling emergencies and using emergency services; - reporting maltreatment of vulnerable adults and minors; - assisted living bill of rights; - handling of resident complaints, reporting of complaints, where to report; - consumer advocacy services; and - principles of person-centered planning and service delivery. ULP-G ULP-F was hired on July 24, 2024, to provide direct care services for the licensee. ULP-G's employee records lacked evidence of receiving orientation to assisted living to include the following required content: - overview of assisted living statutes; - review of provider's policies and procedures; - handling emergencies and using emergency services; - reporting maltreatment of vulnerable adults and minors; - handling of resident complaints, reporting of complaints, where to report; and - consumer advocacy services.	{01470}			

Minnesota Department of Health

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{01470}	Continued From page 16 On September 30, 2024, HM-A reviewed ULP-F and ULP-G's employee file and stated it did not include evidence the above trainings had been completed. The licensee's 4.3 Staff Orientation and Education policy dated July 21, 2022, indicated: 3. Orientation topics will include, but not be limited to, the following a. Overview of Minnesota Assisted Living Statute 144G and Minnesota Rules Chapter 4659 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), including requirements based on organizational policy, identification of incidents of maltreatment (abuse, financial exploitation and neglect) and that any act that constitutes maltreatment is prohibited 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, including i. Office of Ombudsman for Long-Term Care ii. Office of Ombudsman for Mental Health and Developmental Disabilities iii. Managed Care Ombudsman at the Department of Human Services iv. County managed care advocates v. Other advocacy services.	{01470}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36116	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 10/01/2024
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{01470}	Continued From page 17	{01470}			
	No further information was provided.				
{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: Based on interview and record review, the licensee failed to ensure one of two employees (unlicensed personnel (ULP)-G) received the required amount of dementia care training in the	{01530}			

Minnesota Department of Health

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{01530}	Continued From page 18 required time frame. 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: During the revisit survey entrance conference on September 30, 2024, at 1:08 p.m., house manager (HM)-A stated the licensee now utilized Educare online training and had assigned staff required trainings that were missing. ULP-G began providing direct care services to the licensee's residents on July 24, 2024. ULP-G's record included four hours and 30 minutes of training for dementia topics, but lacked an additional three hours and 30 minutes of training to meet the required eight hours within 160 working hours of employment start date. On September 30, 2024, at 2:19 p.m. HM-A stated ULP-G had worked greater than 160 hours since start of employment. HM-A reviewed ULP-G's Educare transcript and stated the required eight hours of dementia training had not yet been completed. The licensee's 4.5 Dementia Education policy dated July 21, 2022, indicated: 3. Direct care employees must have completed at least eight (8) hours of initial education within	{01530}			

Minnesota Department of Health

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{01530}	Continued From page 19 160 working hours of the employment start date in the following topics: a. An explanation of Alzheimer's Disease and other dementias b. Assistance with activities of daily living (ADLs) c. Problem solving with challenging behaviors d. Communication skills e. Person-centered planning and service delivery 7. Direct care employees will complete at least two (2) hours of education on topics related to dementia for each twelve (12) months of employment thereafter. No further information was provided.	{01530}			
{01620} SS=E	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	{01620}			

Minnesota Department of Health

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{01620}	Continued From page 20 of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed an assessment within 90 days from the previous survey for one of three residents (R4), and failed to complete a change in condition assessment timely after return from hospitalization for one of two residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at 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: R4 R4 was admitted to the assisted living facility on February 7, 2022, with diagnoses including schizoaffective disorder. R4's last two assessments dated June 22, 2024, and September 22, 2024, were provided. 92 days had passed between assessments, thus exceeding 90 calendar days.	{01620}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36116	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 10/01/2024
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{01620}	Continued From page 21 R3 R3 was admitted to the assisted living facility on December 6, 2023, with diagnoses including schizophrenia. R3's last assessment was dated September 14, 2024. The reason for the assessment indicated: Hospitalization. R3's progress note dated September 11, 2024, at 12:42 p.m. indicated R3 had an emergency relocation to the hospital after acting aggressively towards a staff and damaging a car. Subsequent progress notes dated September 12, 2024, indicated R3 had returned to the licensee. On October 1, 2024, at 10:42 a.m. clinical nurse supervisor (CNS)-H stated R4 had returned from hospitalization on September 12, 2024; however, she had not completed his change of condition assessment until September 14, 2024 (two days later). CNS-H reviewed R4's last assessment and stated it had been completed two days late by the former CNS. The licensee's 2.3 Assessment and Reassessment policy dated July 21, 2022, indicated: 8. Ongoing resident reassessments must be conducted by an RN and cannot exceed 90 days from the last date of assessment. 10. Ongoing resident monitoring must be conducted as needed based on changes in the needs of the resident and may be completed by other licensed nurses acting within their scope of licenses. No further information was provided.	{01620}			

Minnesota Department of Health

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01650	Continued From page 22	01650			
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a service plan included the correct required content for four of four residents (R1, R3, R4, R5). This practice resulted in a level two violation (a	01650			

Minnesota Department of Health

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01650	Continued From page 23 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: R1 R1's Service Plan Waiver signed July 10, 2024, indicated R1 received assistance with dressing, grooming, housekeeping, laundry, medication administration, blood glucose monitoring, and behavior management. The service plan indicated a registered nurse (RN) assessment would be conducted within the first five days of the initiation of services to determine needs and develop a service plan. The service plan identified an incorrect schedule and method of monitoring assessments of the resident. R3 R3's Service Plan Waiver signed September 30, 2024, indicated R3 received assistance with grooming, showering, housekeeping, laundry, medication administration, and behavior management. The service plan included a RN assessment would be conducted within the first five days of the initiation of services to determine needs and develop a service plan. The service plan identified an incorrect schedule and method of monitoring assessments of the resident. R4 R4's Service Plan Waiver signed June 10, 2024, indicated R4 received assistance with grooming, showering, incontinence care, housekeeping, laundry, medication administration, and behavior	01650			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36116	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 10/01/2024
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01650	Continued From page 24 management. The service plan included a RN assessment would be conducted within the first five days of the initiation of services to determine needs and develop a service plan. The service plan identified an incorrect schedule and method of monitoring assessments of the resident. R5 R5's Service Plan Waiver signed July 10, 2024, indicated R5 received assistance with grooming, showering, housekeeping, laundry, medication administration, and behavior management. The service plan included a RN assessment would be conducted within the first five days of the initiation of services to determine needs and develop a service plan. The service plan identified an incorrect schedule and method of monitoring assessments of the resident. On October 1, 2024, at 9:18 a.m. house manager (HM)-A stated the above required content was incorrect in the service plan, and reflective of previous home care statutes. The licensee's Service Plan policy dated August 1, 2021, indicated: 8. The service plan includes the following: d. The schedule and methods of monitoring reviews or assessments of the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	01650			
{01760} SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted	{01760}			

Minnesota Department of Health

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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
{01760}	Continued From page 25 living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were clarified and transcribed correctly per physician order for one of two residents (R1) observed during medication observation. 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's diagnoses included diabetes. R1's Service Plan signed July 10, 2024, indicated R1 received assistance with medication administration.	{01760}			

Minnesota Department of Health

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{01760}	Continued From page 26 R5's prescriber orders dated September 26, 2024, included: degludec (commonly known as Tresiba) 100 unit/ml (milliliter) FlexTouch pen. Inject 0.3 ml (30 units) subcutaneously daily. On October 1, 2024, at 10:01 a.m. the surveyor observed house manager (HM)-A obtain R1's Tresiba insulin pen from the locked medication closet. HM-A stated R1 prepared and administered his own insulin under staff observation. The label on the Tresiba insulin pen indicated to inject 36 units daily. The surveyor asked R1 what dosage of the Tresiba insulin he received. R1 stated the dosage had changed from 36 units daily to 30 units daily "a couple months ago". HM-A observed R1 prepare and administer the insulin. HM-A stated the Tresiba insulin pen label and the order in R1's MAR both indicated to administer 36 units daily, not 30 units daily per physician order. HM-A further stated when staff initial the MAR for the Tresiba insulin they also record the number of units administered by R1. On October 1, 2024, at 10:42 a.m. clinical nurse supervisor (CNS)-H reviewed R1's current physician orders and stated the Tresiba order in the MAR and the label on R1's Tresiba insulin pen were inaccurate. CNS-H stated being new to the position and had not realized the order had changed. The licensee's Medication Administration policy dated August 1, 2021, indicated: 6. All staff with responsibility for medication administration have access to information about the medication being administered, including but not limited to: a. Purpose b. Dosage	{01760}			

Minnesota Department of Health

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{01760}	Continued From page 27 c. Route d. Frequency e. Instructions related to the medication and specific to the residents, as appropriate f. Side effect g. Resident allergies to medications 7. The licensed nurse is responsible for assessing medications to assure that all medications are current and ordered by the prescriber and to identify any expired or outdated medications, which will be disposed according to policy. No further information provided.	{01760}			
{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 ensure accurate prescription labeling for one of one resident (R1) with an insulin pen. 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	{01890}			

Minnesota Department of Health

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{01890}	Continued From page 28 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's diagnoses included diabetes. R1's Service Plan signed July 10, 2024, indicated R1 received assistance with medication administration. R5's prescriber orders dated September 26, 2024, included: degludec (commonly known as Tresiba) 100 unit/ml (milliliter) FlexTouch pen. Inject 0.3 ml (30 units) subcutaneously daily. On October 1, 2024, at 10:01 a.m. the surveyor observed house manager (HM)-A obtain R1's Tresiba insulin pen from the locked medication closet. HM-A stated R1 prepared and administered his own insulin under staff observation. The label on the Tresiba insulin pen indicated to inject 36 units daily. The surveyor asked R1 what dosage of the Tresiba insulin he received. R1 stated the dosage had changed from 36 units daily to 30 units daily "a couple months ago". HM-A observed R1 prepare and administer the insulin. HM-A stated the Tresiba insulin pen label and the order in R1's MAR both indicated to administer 36 units daily, not 30 units daily per physician order. HM-A further stated when staff initaled the MAR for the Tresiba insulin they also recorded the number of units administered by R1. On October 1, 2024, at 10:42 a.m. clinical nurse supervisor (CNS)-H reviewed R1's current physician orders and stated the Tresiba order in the MAR and the label on R1's Tresiba insulin pen were inaccurate. CNS-H stated being new to	{01890}			

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{01890}	Continued From page 29 the position and had not realized the order had changed. The licensee's Medication Administration policy dated August 1, 2021, indicated: 7. The licensed nurse is responsible for assessing medications to assure that all medications are current and ordered by the prescriber and to identify any expired or outdated medications, which will be disposed according to policy. No further information was provided.	{01890}			
{02320} SS=D	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure delegated procedures were followed for one of two residents (R5) observed during medication administration. 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	{02320}			

Minnesota Department of Health

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{02320}	Continued From page 30 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R5's Service Plan Waiver signed July 10, 2024, indicated R5 received services including medication administration. On October 1, 2024, at 9:32 a.m. unlicensed personnel (ULP)-D was observed setting up medications to administer for R5. R5's medications had been set up by the pharmacy in one blister package for each time of administration. The package listed the name and dosage of each medication on the top of the blister package. ULP-D opened the blister package he had obtained from R5's medication bin, and without first comparing each medication to the order in R5's medication administration record (MAR), poured the seven medications into the palm of R5's hand. R5 stated these were not his morning medications, they were his bedtime medications. ULP-D apologized, took the medications back from R5, and obtained the correct blister package containing R5's AM medications. ULP-D then, without comparing the listed medications on top of the blister package against R5's MAR, poured the two medications into the palm of R5's hand and observed him take the medications. Immediately following the observation ULP-D stated the AM and bedtime medication packages were color-coded and he should have caught that. ULP-D further stated he did not check R5's MAR against the label on the blister package and should have. On October 1, 2024, at 10:42 a.m. clinical nurse supervisor (CNS)-H stated she would expect staff to compare residents' medication labels with the	{02320}			

Minnesota Department of Health

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{02320}	Continued From page 31 orders in the MAR when setting up medications for administration. The licensee's Medication Administration policy dated August 1, 2021, indicated: 6. All staff with responsibility for medication administration have access to information about the medication being administered, including but not limited to: a. Purpose b. Dosage c. Route d. Frequency e. Instructions related to the medication and specific to the residents, as appropriate f. Side effect g. Resident allergies to medications. No further information was provided.	{02320}			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

August 6, 2024

Licensee

Merrcy Care Home LLC

1609 Edgewood Avenue South

Saint Louis Park, MN 55426

RE: Project Number(s) SL36116015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 10, 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 . . ."

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 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>

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,



Jodi Johnson, Supervisor

State Evaluation Team

Email: jodi.johnson@state.mn.us

Telephone: 507-344-2730 Fax: 1-866-890-9290

JMD

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36116	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/10/2024
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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: SL36116015 On July 8, 2024, through, July 10, 2024, 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 resident(s); four receiving services under the provider's Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
0 250 SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a	0 250			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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0 250	Continued From page 1 provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4, or interferes with or impedes access by the Office of Ombudsman for Mental Health and Developmental Disabilities according to section 245.94, subdivision 1; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter;	0 250			

Minnesota Department of Health

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0 250	Continued From page 2 (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to show they met the requirements of licensure, by attesting the managerial officials who oversaw the day-to-day operations understood applicable statutes and rules; nor developed and/or implemented current policies and procedures as required with records reviewed. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems 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: During the entrance conference on July 8, 2024,	0 250			

Minnesota Department of Health

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0 250	Continued From page 3 at 11:59 a.m., house manager (HM)-A stated the licensee's employees in charge of the facility were familiar with the assisted living regulations and the licensee provided medication and treatment management services. The licensee's Application for Assisted Living License, section titled Official Verification of Owner or Authorized Agent, (page four and five of the application), identified, I certify I have read and understand the following: [a check mark was placed before each of the following]: - I have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section] 144G.45, my building(s) must comply with subdivisions 1-3 of the section, as applicable section Laws 2020, 7th Spec. [special] Sess [session]., chpt. [chapter] 1. art. [article] 6, sect. 17. - I have read and fully understand Minn. Stat. sect. 144G.80, 144G.81. and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22, my building(s) must comply with these sections if applicable. - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G. - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659. - Reporting of Maltreatment of Vulnerable Adults. - Electronic Monitoring in Certain Facilities. - I understand pursuant to Minn. Stat. sect. 13.04 Rights of Subjects of Data, the Commissioner will use information provided in this application, which	0 250			

Minnesota Department of Health

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0 250	Continued From page 4 may include an in-person or telephone conference, to determine if the applicant meets requirements for assisted living licensing. I understand I am not legally required to supply the requested information; however, failure to provide information or the submission of false or misleading information may delay the processing of my application or may be grounds for denying a license. I understand that information submitted to the commissioner in this application may, in some circumstances, be disclosed to the appropriate state, federal or local agency and law enforcement office to enhance investigative or enforcement efforts or further a public health protective process. Types of offices include Adult Protective Services, offices of the ombudsmen, health-licensing boards, Department of Human Services, county or city attorneys' offices, police, local or county public health offices. - I understand in accordance with Minn. Stat. sect. 144.051 Data Relating to Licensed and Registered Persons (opens in a new window), all data submitted on this application shall be classified as public information upon issuance of a provisional license or license. All data submitted are considered private until MDH issues a license. - I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659 governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. - I have examined this application and all	0 250			

Minnesota Department of Health

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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
0 250	Continued From page 5 attachments and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct, and complete. I will notify MDH, in writing, of any changes to this information as required. - I attest to have all required policies and procedures of Minn. Stat. chapter 144G and Minn. Rules chapter 4659 in place upon licensure and to keep them current as applicable. Page four was electronically signed by HM-A on May 13, 2023. The licensee had an assisted living license issued on July 1, 2024, with an expiration date of June 30, 2025. The licensee failed to ensure the following policies and procedures were developed and/or implemented: (3) orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; (6) conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate; (10) conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards; (12) medication and treatment management;	0 250			

Minnesota Department of Health

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0 250	Continued From page 6 (13) delegation of tasks by registered nurses or licensed health professionals; As a result of this survey, the following orders were issued 0650, 0660, 1370, 1380, 1470, 1500, 1530, 1620, 1750, 1760, and 1890, indicating the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.08 to 144G.95. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 250			
0 470 SS=C	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for 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	0 470			

Minnesota Department of Health

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0 470	Continued From page 7 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 staffing schedule was posted as required, potentially affecting the licensee's current residents and any visitors. 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: The licensee lacked a daily staffing schedule developed by the clinical nurse supervisor per Assisted Living Facilities: Minnesota Rules Chapter 4659.0180 Subp. 4. to: - include direct-care staff work schedules for each direct-care staff member showing all work shifts, including days and hours worked; - identify the direct-care staff member's resident assignments or work location; and - be posted after redacting direct-care staff member's resident assignments, at the beginning of each work shift in a central location in each building.	0 470			

Minnesota Department of Health

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0 470	Continued From page 8 On July 8, 2024, at 11:00 a.m. upon entrance into the facility, the surveyor observed the licensee's posted documents. There was no evidence of a staff schedule posting. During the entrance conference on July 8, 2024, at 11:59 a.m. house manager (HM)-A stated the daily staff schedule was not posted for residents and visitors. The licensee's 2.15 Staffing policy dated July 21, 2022, noted the schedule is posted at the beginning of the shift in a central location in each building, if applicable, accessible to staff, residents, volunteers, and the public. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 470			
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, 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	0 480			

Minnesota Department of Health

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0 480	Continued From page 9 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 (FBEIR) dated July 9, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480			
0 650 SS=D	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	0 650			

Minnesota Department of Health

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0 650	Continued From page 10 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 interview and record review, the licensee failed to ensure employee records included all required content for one of two employees (unlicensed personnel (ULP)-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, 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-C began providing direct care services for the licensee on January 1, 2023. ULP-C's record lacked an annual performance review that identified areas of improvement needed and training needs. On July 9, 2024, at 1:38 p.m. house manager (HM)-A stated ULP-C's record did not include evidence of an annual performance review since hire. The licensee's 4.9 Personnel Records policy dated July 21, 2022, indicated employee records for each person will include documentation of annual performance reviews that identify areas of improvement needed and training needs.	0 650			

Minnesota Department of Health

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0 650	Continued From page 11 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 interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) including documentation of completion of a two-step TST (tuberculin skin test) or other evidence of TB screening such as a blood test for one of two employees (unlicensed personnel (ULP)-D).	0 660			

Minnesota Department of Health

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0 660	Continued From page 12 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: The licensee's TB risk assessment dated January 1, 2024, indicated the licensee was a low risk. ULP-D had a start date of June 11, 2024. ULP-D's employee's record contained a TB Baseline Screening Tool for Health Care Workers form dated June 11, 2024. ULP-D's record did not include evidence TB testing had been completed. On July 8, 2024, at 3:20 p.m. house manager (HM)-A stated ULP-D had a TB blood test upon hire, but he did not have a copy of the results for the employee file. The Minnesota Department of Health, Regulations for Tuberculosis Control in Health Care Settings dated July 2013, indicated: Baseline TB screening is required for all HCWs (health care workers) (Table 3.1). Baseline TB screening consists of three components: 1. Assessing for current symptoms of active TB disease, 2. Assessing TB history, and 3. Testing for the presence of infection with	0 660			

Minnesota Department of Health

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0 660	Continued From page 13 Mycobacterium tuberculosis by administering either a two-step TST or single IGRA (Interferon Gamma Release Assay - a blood test used to see whether a person has been infected with the bacteria causing TB). The 2-step TST identified as: Procedure used for the baseline skin testing of persons who will receive serial TSTs (e.g., HCWs and residents of long term-care facilities) to reduce the likelihood of mistaking a boosted reaction for a new infection. If an initial TST result is classified as negative, a second step of a two-step TST should be administered 1-3 weeks after the first TST result was read. If the second TST result is positive, it probably represents a boosted reaction, indicating infection most likely occurred in the past and not recently. If the second TST result is also negative, the person is classified as not infected. The licensee's 4.14 Tuberculosis Screening/Prevention policy dated July 21, 2022, indicated baseline testing is completed on hire for all direct care providers and anyone who visits residents (including volunteers). 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	0 680			

Minnesota Department of Health

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0 680	Continued From page 14 temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a written emergency preparedness plan with all the required content as defined in Appendix Z. This had the potential to affect all residents, staff and visitors at the assisted living facility license. 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 the residents).	0 680			

Minnesota Department of Health

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0 680	Continued From page 15 The findings include: The licensee's Emergency Preparedness binder lacked the following required content: - develop and maintain an EP training and testing program; and - conduct exercises to test EP at least twice per year, including unannounced staff drills using EP, including participating in an annual full-scale exercise community based or annual individual facility based functional exercise or if facility experiences an actual emergency requiring evacuation of plan, facility is exempt from engaging in its next required full scale exercise; conduct an additional annual exercise that may include a second full scale exercise community based or an individual; facility based functional exercise or mock disaster drill or table top exercise. On July 9, 2024, at 2:30 p.m. house manager (HM)-A stated they had not done any trainings with the staff other than fire drills in the past year. HM-A stated the did have to implement their plan for power outage recently due to excessive rain but did not write it up and was unaware of the requirement. Also, since discontinuing the use of Educare for training, they have not documented providing emergency trainings upon hire and yearly. The licensee's 1.4 Emergency Plan dated 2022, indicated: Exercises are conducted at least annually to test the emergency plan, including unannounced staff drills using emergency procedures. The facility will participate in one full-scale exercise that is either community based with participating state and local agencies and some regional entities such as health care coalitions, or, if a community-based exercise is	0 680			

Minnesota Department of Health

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0 680	Continued From page 16 not accessible, an individual, facility based. A full-scale exercise does not require physically moving residents; the facility can perform a simulated full-scale exercise. If the facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the facility is exempt from engaging in a community-based or individual, facility-based full-scale exercise for one year following the onset of the actual event. The facility will conduct an additional exercise that may include a table-top exercise that uses clinically relevant emergency scenarios to challenge and emergency plan. The facility will analyze its response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the facility's facility emergency plan as needed. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story	0 780			

Minnesota Department of Health

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0 780	Continued From page 17 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 are interconnected so that the actuation of one alarm causes all alarms in the dwelling unit to actuate. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On a facility tour on July 10, 2024, at approximately 9:45 a.m. with house manager (HM)-A. HM-A tested the smoke alarms throughout the home. It was observed that when the smoke alarms were push button tested, some	0 780			

Minnesota Department of Health

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0 780	Continued From page 18 of the alarms did not operate. All the smoke alarms in the residence where not interconnected. The deficient conditions were visually verified by HM-A 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 provide or maintain fire extinguishers as required throughout the facility. This deficient condition had the ability to affect all staff, visitors, 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) and was issued at a	0 790			

Minnesota Department of Health

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0 790	Continued From page 19 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 July 10, 2024, at 9:45 a.m., with House Manager (HM)-A, it was observed that the required fire extinguishers had not had the annual inspection completed. Fire extinguishers are required to be inspected annually by a competent person. The last time this was completed was April 2023. The deficient conditions were visually verified by the HM-A accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 790			
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the facility's physical environment in a continuous state of good repair	0 800			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36116	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/10/2024
NAME OF PROVIDER OR SUPPLIER MERRCY CARE HOME LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1609 EDGEWOOD AVENUE SOUTH SAINT LOUIS PARK, MN 55426			
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0 800	Continued From page 20 and operation regarding the health, safety, and well-being of the residents. 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 a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the facility tour on July 10, 2024, with the house manager (HM)-A, between 9:30 a.m. and 11:30 a.m. the following facility hazards and disrepair were observed: Electrical: Surveyor observed the cover was missing on the main electrical panel in the garage. Surveyor observed the connection to the light in laundry room in the basement was not inside an electrical box. Surveyor explained to the HM-A, that all covers shall be always kept on all electrical panels/receptacles/switches etc. and all electrical connections shall be inside a box, completed by a licensed electrician. Extension Cord: Surveyor observed extension cords being used permanently and routed through the ceiling in the	0 800			

Minnesota Department of Health

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0 800	Continued From page 21 lower-level bedroom. Surveyor explained to the HM-A, that extension cords cannot be used as a permanent means of wiring. Escape Windows: Surveyor observed window air conditioners installed in the only escape windows in both upper-level bedrooms. (Bedrooms 2 and 3) Surveyor explained to the HM-A, that the escape windows shall be always accessible and shall not be blocked with the air conditioners. Garage Ceiling Access: Surveyor observed the attic access in the garage was removed an open. Surveyor explained to the HM-A, that the attic access cover shall be always kept in place. Garage Storage: Surveyor observed the garage had an excessive amount of combustible material and flammable/gas powered equipment. (motorcycles/gas powered bikes/jet ski) The gas-powered equipment was being worked on by a resident. Surveyor explained to the HM-A, that the storage shall be neat, orderly and the exit path be always kept clear. The deficient conditions were visually verified by the HM-A accompanying on the tour.	0 800			

Minnesota Department of Health

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0 800	Continued From page 22	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) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill.	0 810			

Minnesota Department of Health

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0 810	Continued From page 23 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to provide required training and drills for residents. 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: Training: During record review, a copy of resident training records and the training policy were requested, but were not able to be provided. During interview HM-A stated they had no further documentation to provide. During record review, a copy of employee training records and the training policy were requested, but were not able to be provided. During interview HM-A stated they had no further documentation to provide. Drills: During interview a copy of evacuation drill documentation and policy were requested. HM-A provided some drill documentation, but it lacked the required signatures and was performed only	0 810			

Minnesota Department of Health

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0 810	Continued From page 24 annually. Surveyor explained to the HM-A, the evacuation drills shall be completed and documented with employee signatures. The deficient conditions were verified by the HM-A after the above review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810			
0 820 SS=F	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. 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. This had the potential to directly affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 820			

Minnesota Department of Health

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0 820	Continued From page 25 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). Findings include: On a facility tour on July 10, 2024, at approximately 10:45 a.m. with the House Manager (HM)-A, it was observed cigarette butts were discarded on the ground outside the front door and garage. The surveyor explained to the House Manager HM-A, that all cigarette butts shall be properly discarded into an approved container and that cigarette smoking should take place in the designated area away from the structure. The deficient conditions were visually verified by the HM-A accompanying on the tour. TIME PERIOD FOR CORRECTION: Two (2) days.	0 820			
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation;	01060			

Minnesota Department of Health

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01060	Continued From page 26 (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation for one of one resident (R1).	01060			

Minnesota Department of Health

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01060	Continued From page 27 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: R1 began receiving assisted living services from the licensee on August 1, 2021. R1's unsigned, service plan, printed July 9, 2024, indicated R1 received services including assistance with dressing, grooming, housekeeping, laundry, medication administration, blood glucose monitoring, and behavior management. R1's After Visit Summary revealed R1 had been hospitalized on March 18, 2024, and returned to the assisted living facility on March 22, 2024. R1's medical record did not include evidence an emergency relocation notice had been provided for the above hospitalization. On July 9, 2024, at 12:14 p.m. house manager (HM)-A stated they do not provide a written notice for an emergency relocation to residents that are hospitalized, nor do they contact the ombudsman if gone greater than four days. HM-A further stated being unaware of the requirement. The licensee's 2.16 Discharge and Transfer of Residents policy dated July 21, 2022, indicated: 25. In the event of an emergency relocation, the facility will, as soon as possible, provide written	01060			

Minnesota Department of Health

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01060	Continued From page 28 notice of Emergency Relocation to the following: a. The resident b. The resident's legal representative c. The resident's designated representative d. If the resident receives home and community-based services, the resident's case manager e. If the resident has been relocated and not return to the licensee within four (4) days, the Office of Ombudsman for Long-Term Care f. Notice of the right to appeal the decision under 144G.54 No further information was provided. TIME PERIOD TO CORRECT: Twenty-one (21) days	01060			
01370 SS=D	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls;	01370			

Minnesota Department of Health

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01370	Continued From page 29 (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and competency evaluations were completed as required prior to providing direct care for one of two unlicensed personnel (ULP-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include:	01370			

Minnesota Department of Health

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01370	Continued From page 30 ULP-D was hired to provide direct care services on June 11, 2024. ULP-D's record lacked evidence the following education and/or competencies had been completed prior to providing direct cares: - documentation requirements for all services provided; - basic infection control, including blood-borne pathogens; - maintenance of a clean and safe environment; - training on the prevention of falls for providers working with the elderly or individuals at risk of falls; - basic nutrition, meal preparation, food safety, and assistance with eating; - preparation of modified diets as ordered by a licensed health professional; - communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; - awareness of confidentiality and privacy; - understanding appropriate boundaries between staff and clients and the client's family; -Procedures to utilize in handling various emergency situations. On July 8, 2024, house manager (HM)-A stated the licensee used to utilize an online electronic training platform (Educare) for the above trainings; however, they discontinued and were now completing all training on paper. HM-A reviewed ULP-D's employee file and stated it did not include evidence the above training had been completed prior to providing services. The licensee's Staff Competency policy dated July 21, 2022, indicated:	01370			

Minnesota Department of Health

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01370	Continued From page 31 3. Training and competency evaluations for all unlicensed personnel include the following. a. Documentation requirements for all services provided c. Basic infection control, including blood-borne pathogens d. Maintenance of a clean and safe environment f. Training on the prevention of falls for providers working with the elderly or those at risk of falls. i. Basic nutrition, meal preparation and preparation of modified diets as ordered by a licensed health professional, food safety and assistance with eating. j. Communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preference, cultural background and family k. Awareness of confidentiality and privacy l. Understanding appropriate boundaries between staff, residents and the resident's family m. Procedures to utilize in handling various emergency situations No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370			
01380 SS=D	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and	01380			

Minnesota Department of Health

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01380	Continued From page 32 changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency evaluations were completed as required prior to providing direct care for one of two unlicensed personnel (ULP-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-D was hired to provide direct care services on June 11, 2024. ULP-D's record lacked evidence the following education and/or competencies had been completed prior to providing direct cares: - observing, reporting, and documenting resident status;	01380			

Minnesota Department of Health

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01380	Continued From page 33 - basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; and - recognizing physical, emotional, cognitive, and developmental needs of the client. On July 8, 2024, house manager (HM)-A stated the licensee used to utilize an online electronic training platform (Educare) for the above trainings; however, they discontinued and were now completing all training on paper. HM-A reviewed ULP-D's employee file and stated it did not include evidence the above training had been completed prior to providing services. The licensee's Staff Competency policy dated July 21, 2022, indicated: 4. Home Health Aides (HHA) providing assisted living services and who have not completed a state-approved formal training and competency evaluation program will demonstrate competency through the following process a. Satisfactory completion of an oral or written test on the tasks the HHA will perform. b. Home Health Aides may not work for the licensee until they have successfully passed the written and demonstration competency evaluation, including satisfactory completion of the following i. Observation, reporting and documenting of resident status ii. Basic knowledge of body functioning and changes in body function, injuries or other reportable changes iii. Recognizing physical, emotional, cognitive, and development needs of the resident. No further information was provided.	01380			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36116	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/10/2024
NAME OF PROVIDER OR SUPPLIER MERRCY CARE HOME LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1609 EDGEWOOD AVENUE SOUTH SAINT LOUIS PARK, MN 55426			
(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
01380	Continued From page 34	01380			
	TIME PERIOD FOR CORRECTION: Twenty-one (21) days				
01470 SS=D	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a),	01470			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36116	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/10/2024
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01470	Continued From page 35 orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure one of one new unlicensed personnel (ULP-D) received orientation to assisted living facility licensing requirements and regulations before providing services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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).	01470			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36116	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/10/2024
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01470	Continued From page 36 The findings include: ULP-D was hired on June 11, 2024, to provide direct care services for the licensee. ULP-D's employee records lacked evidence of receiving orientation to assisted living to include the following required content: - overview of assisted living statutes; - review of provider's policies and procedures; - handling emergencies and using emergency services; - reporting maltreatment of vulnerable adults and minors; - assisted living bill of rights; - handling of resident complaints, reporting of complaints, where to report; - consumer advocacy services; and - principles of person-centered planning and service delivery. On July 8, 2024, house manager (HM)-A stated the licensee used to utilize an online electronic training platform (Educare) for the above trainings; however, they had discontinued and were now completing all training on paper. HM-A reviewed ULP-D's employee file and stated it did not include evidence the above training had been completed prior to providing services. The licensee's 4.3 Staff Orientation and Education policy dated July 21, 2022, indicated: 3. Orientation topics will include, but not be limited to, the following a. Overview of Minnesota Assisted Living Statute 144G and Minnesota Rules Chapter 4659 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	01470			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36116	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/10/2024
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01470	Continued From page 37 d. Handling of emergencies and the use of emergency services e. compliance with Minnesota's Vulnerable Adult (Sections 626.556 and 5572), including requirements based on organizational policy, identification of incidents of maltreatment (abuse, financial exploitation and neglect) and that any act that constitutes maltreatment is prohibited 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, including i. Office of Ombudsman for Long-Term Care ii. Office of Ombudsman for Mental Health and Developmental Disabilities iii. Managed Care Ombudsman at the Department of Human Services iv. County managed care advocates v. Other advocacy services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01470			
01500 SS=F	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	01500			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36116	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/10/2024
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01500	Continued From page 38 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 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;	01500			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36116	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/10/2024
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01500	Continued From page 39 (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 annual training included all required topics for each 12 months of employment for one of one employee (unlicensed personnel (ULP)-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, 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: ULP-C began providing direct care services for the licensee on January 1, 2023. ULP-C's employee record lacked evidence the employee had successfully completed annual training as required, to include the following: - training on reporting of maltreatment of vulnerable adults under section 626.557; - review of the assisted living bill of rights and	01500			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36116	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/10/2024
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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
01500	Continued From page 40 staff responsibilities related to ensuring the exercise and protection of those rights; - 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; disinfection environmental surfaces; and reporting communicable disease; - effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders - 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 - the principals of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. On July 8, 2024, house manager (HM)-A stated the licensee used to utilize an online electronic training platform (Educare) for the above trainings; however, they had discontinued and were now completing all training on paper. HM-A reviewed ULP-C's employee file and training transcript and stated it did not include evidence the above training had been completed annually. The licensee's 4.3 Staff Orientation and Education policy dated July 21, 2022, indicated: 12. All staff providing assisted living services will complete at least eight (8) hours of education for every twelve (12) months of employment. 13. Education topics will include, but not be	01500			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36116	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/10/2024
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01500	Continued From page 41 limited to, the following a. Reporting of maltreatment of adults b. Review of Assisted Living Bill of Rights and staff responsibilities related to ensuring the exercise and protection of those rights c. Review of the organization's policies and procedures related to provision of assisted living services and how to implement them d. Infection control techniques used in the home e. Effective approaches to use to problem solve when working with a resident's challenging behaviors and how to communicate with residents who have dementia, Alzheimer's Disease or relate disorder f. The principle of person-centered planning and service delivery and how they apply to direct support services provided by staff. 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	01530			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36116	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/10/2024
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01530	Continued From page 42 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: Based on observation, interview, and record review, the licensee failed to ensure one of two employees (unlicensed personnel (ULP)-C) received the required amount of dementia care training in the required time frame. 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-C began providing direct care services to the licensee's residents on January 1, 2023. ULP-C's employee record did not include evidence any dementia training had been	01530			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36116	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/10/2024
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01530	Continued From page 43 completed since starting employment. On July 8, 2024, house manager (HM)-A stated the licensee used to utilize an online electronic training platform (Educare) for the above trainings; however, they had discontinued and were now completing all training on paper. HM-A reviewed ULP-C's employee file and Educare training transcript and stated it did not include evidence the required eight hours of dementia training had been completed upon hire, nor two hours annually. The licensee's 4.5 Dementia Education policy dated July 21, 2022, indicated: 3. Direct care employees must have completed at least eight (8) hours of initial education within 160 working hours of the employment start date in the following topics: a. An explanation of Alzheimer's Disease and other dementias b. Assistance with activities of daily living (ADL's) c. Problem solving with challenging behaviors d. Communication skills e. Person-centered planning and service delivery 7. Direct care employees will complete at least two (2) hours of education on topics related to dementia for each twelve (12) months of employment thereafter. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01530			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36116	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/10/2024
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01620	Continued From page 44	01620			
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed a comprehensive reassessment not to exceed 90 calendar days from the last assessment for one of one resident (R1), and failed to conduct a change of condition assessment following hospitalization for one of one resident (R1). This practice resulted in a level two violation (a	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36116	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/10/2024
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01620	Continued From page 45 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's unsigned, service plan, printed July 9, 2024, indicated R1 received services including assistance with dressing, grooming, housekeeping, laundry, medication administration, blood glucose monitoring, and behavior management. R1's After Visit Summary revealed the resident had been hospitalized on March 18, 2024, and returned to the assisted living facility on March 22, 2024. R1's last three assessments were requested. Assessments dated December 4, 2023, March 4, 2024, and June 4, 2024, were provided. 92 days had passed between the December 2023, and March 2024, assessments (2 days late), and the March 2024, and June 2024, assessments (2 days late). In addition, a change of condition assessment had not been completed upon R1's return from hospitalization on March 22, 2024. On July 10, 2024, at 11:42 a.m. clinical nurse supervisor (CNS)-B reviewed R1's assessments and stated the last two 90 day assessments were late and also stated there was no evidence a change of condition assessment had been completed upon R1's return from hospitalization on March 22, 2024.	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36116	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/10/2024
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01620	Continued From page 46 The licensee's 2.3 Assessment and Reassessment policy dated July 21, 2022, indicated: 8. Ongoing resident reassessments must be conducted by an RN and cannot exceed 90 days from the last date of assessment. 10. Ongoing resident monitoring must be conducted as needed based on changes in the needs of the resident and may be completed by other licensed nurses acting within their scope of licenses. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620			
01640 SS=D	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 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,	01640			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36116	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/10/2024
NAME OF PROVIDER OR SUPPLIER MERRCY CARE HOME LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1609 EDGEWOOD AVENUE SOUTH SAINT LOUIS PARK, MN 55426			
(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 47 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 observation, interview, and record review, the licensee failed to ensure a signed current service plan was implemented for one of one resident (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 began receiving assisted living services from the licensee on August 1, 2021. On July 9, 2024, at 10:23 a.m. unlicensed personnel (ULP)-E was observed administering medication to R1. R1's service plan printed July 9, 2024, indicated R1 received services including assistance with dressing, grooming, housekeeping, laundry, medication administration, blood glucose monitoring, and behavior management. The service plan was not signed by R1 or the licensee. On July 9, 2024, at 1:00 p.m. house manager	01640			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36116	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/10/2024
NAME OF PROVIDER OR SUPPLIER MERRCY CARE HOME LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1609 EDGEWOOD AVENUE SOUTH SAINT LOUIS PARK, MN 55426			
(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 48 (HM)-A stated R1's service plan had not been signed by the licensee or R1. The licensee's Service Plan policy dated August 1, 2021, indicated: 4. The initial service plan and any revisions are signed by a representative from the facility and the resident or resident's representative, indicating agreement with the services to be provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640			
01750 SS=D	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse documented resident-specific instructions for insulin medication, for one of one resident (R1) receiving insulin whose medication	01750			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36116	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/10/2024
NAME OF PROVIDER OR SUPPLIER MERRCY CARE HOME LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1609 EDGEWOOD AVENUE SOUTH SAINT LOUIS PARK, MN 55426		
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01750	Continued From page 49 administration was delegated to unlicensed personnel. 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's unsigned, service plan, printed July 9, 2024, indicated R1 received services including medication administration. R1's After Visit Summary dated June 24, 2024, included the following order: Novolog (insulin) 100 units/milliliter FlexPen. Inject 10 - 15 units with each meal, take 5 units with snacks. Maximum daily dose 60 units. On July 9, 2024, at 10:23 a.m. unlicensed personnel (ULP)-E was observed administering medications to R1 including Novolog insulin. ULP-E handed the Novolog insulin pen to R1 who then applied the needle, dialed up the dose to 15 units, and administered independently while ULP-E observed. ULP-E indicated R1 always administered 15 units of the Novolog insulin with each meal. On July 10, 2024, at 11:42 a.m. clinical nurse supervisor (CNS)-B reviewed R1's Novolog insulin order and stated it did not have clear parameters on how much insulin should be administered at each meal. CNS-B stated R1	01750			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36116	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/10/2024
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01750	Continued From page 50 used to be fully in charge of his insulin administration but was forgetting to complete it; R1's physician wanted staff oversight to ensure the resident was getting his scheduled insulin. The licensee's Medication Administration policy dated August 1, 2021, indicted: 3. The registered nurse may delegate medication administration to an unlicensed staff member (home health aide) according to the following protocol. a. All home health aides have passed a competency evaluation with respect to all medications routes to be administered. b. The registered nurse has prepared written instructions for the home health aide in the proper methods to administer medications with respect to each resident. c. The registered nurse has communicated with/provided orientation to the home health aide regarding the individual needs of the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750			
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36116	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/10/2024
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01760	Continued From page 51 completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were clarified and transcribed correctly per physician order for one of one resident (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's unsigned, service plan, printed July 9, 2024, indicated R1 received services including medication administration. R1's After Visit Summary dated June 24, 2024, included the following order: Novolog (insulin) 100 units/milliliter FlexPen. Inject 10 - 15 units with each meal, take 5 units with snacks. Maximum daily dose 60 units. On July 9, 2024, at 10:23 a.m. unlicensed personnel (ULP)-E was observed administering medications to R1 including Novolog insulin. ULP-E handed the Novolog pen to R1 who then applied the needle, dialed up the dose to 15 units,	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36116	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/10/2024
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01760	Continued From page 52 and administered independently while ULP-E observed. When interviewed immediately following the observation, ULP-E stated R1 always administered 15 units of the Novolog insulin with each meal. ULP-E further stated he signed off on R1's medication administration record (MAR) that the insulin was administered but did not indicate how many units were received. On July 10, 2024, at 11:42 a.m. clinical nurse supervisor (CNS)-B reviewed R1's Novolog insulin order and stated it did not have clear parameters on how much insulin should be administered at each meal, nor were staff documenting how much of the Novolog insulin R1 was administering with meals. CNS-B further stated the order for five units of Novolog insulin with snacks was not transcribed separately in the MAR as the resident usually did not eat snacks in between meals. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760			
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			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36116	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/10/2024
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01890	Continued From page 53 Based on observation, interview, and record review, the licensee failed to ensure medications were maintained bearing the original prescription label and included the date opened of a time-sensitive drug, for one of one resident (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's diagnoses included diabetes. R1's unsigned, service plan, printed July 9, 2024, indicated R1 received services including medication administration. R1's After Visit Summary dated June 24, 2024, included the following order: Novolog (insulin) 100 units/milliliter (ml) FlexPen. Inject 10 - 15 units with each meal, take 5 units with snacks. Maximum daily dose 60 units; and Tresiba (insulin) 100 unit/ml FlexTouch pen. Inject 0.4 mg (40 units) subcutaneously daily. On July 9, 2024, at 10:23 a.m. unlicensed personnel (ULP)-E was observed setting up R1's morning medications for administration including the Novolog and Tresiba insulin. Neither insulin pen had a current original pharmacy label or an opened date on the pen. ULP-E stated the pharmacy did not provide a label for each individual insulin pen though there was a label on	01890			

Minnesota Department of Health

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01890	Continued From page 54 the box the pens came in. ULP-E further stated he never dated the insulin pens when opened and was unaware of the requirement. On July 10, 2024, at 11:42 a.m. clinical nurse supervisor (CNS)-B stated the pharmacy did not provide a label for each individual insulin pen and a label was not kept with the opened insulin pens. CNS-B further stated insulin pens should be dated when opened. The Novolog insulin manufacturer's package insert revised February 2023, indicated Novolog FlexPen insulin expires 28 days after opening. The Tresiba insulin manufacturer's package insert revised December 2016, indicted Tresiba FlexTouch insulin pen expires 56 days after opening. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890			
02320 SS=D	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	02320			

Minnesota Department of Health

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02320	Continued From page 55 review, the licensee failed to ensure delegated procedures were followed for one of two residents (R1) observed during medication administration. 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's diagnoses included diabetes. R1's unsigned, service plan, printed July 9, 2024, indicated R1 received services including medication administration. On July 9, 2024, at 10:23 a.m. unlicensed personnel (ULP)-E was observed setting up medications to administer for R1. 11 of R1's oral medications had been set up by the pharmacy in one blister package. The package listed the name and dosage of each medication on the top of the blister package. ULP-E opened the blister package and poured the 11 medications into a medication cup without comparing what was listed on the top of the package with R1's medication administration record (MAR). ULP-E then set-up R1's two narcotic medications that were in bottles. ULP-E poured the scheduled amount of each medication into the cap of the bottle then transferred the medication into the medication cup with the other medications. ULP-E did not compare the labels on the narcotic medications with R1's MAR. ULP-E then	02320			

Minnesota Department of Health

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02320	Continued From page 56 obtained a zipper pouch containing R1's two scheduled insulin pens. ULP-E brought the medication cup and zipper pouch to R1 who was seated at the kitchen table eating breakfast. ULP-E provided R1 the oral medications which R1 consumed independently. ULP-E then opened the zipper pouch and handed R1 the two insulin pens; neither insulin pen had a pharmacy label attached to it or within the zipper pouch. R1 set up the insulin pens independently, dialed up the dose, showed the amount to ULP-E, then administered each insulin independently. ULP-E did not refer to R1's MAR to verify the dosage for each insulin. When interviewed immediately following the observation, ULP-E stated he had not compared R1's medications with the MAR as he had been working at the facility over a year and knew what R1 takes. ULP-E further stated the registered nurse had trained him to compare each medication with the MAR when setting up medications prior to administration. On July 10, 2024, at 11:42 a.m. clinical nurse supervisor (CNS)-B stated he would expect staff to compare residents' medication labels with the orders in the MAR when setting up medications for administration. The licensee's Medication Administration policy dated August 1, 2021, indicated: 6. All staff with responsibility for medication administration have access to information about the medication being administered, including but not limited to: a. Purpose b. Dosage c. Route d. Frequency e. Instructions related to the medication and specific to the residents, as appropriate	02320			

Minnesota Department of Health

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02320	Continued From page 57 f. Side effect g. Resident allergies to medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320			

Type: Full
Date: 07/09/24
Time: 11:00:00
Report: 8041241125

Food and Beverage Establishment Inspection Report

Page 1

Location:

Merrey Care Home Llc
Merrey Care Home LLC
1609 Edgewood Avenue South
St Louis Park, MN55426
Hennepin County, 27

Establishment Info:

ID #: 0037827
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 9525640682
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.

2-200 Employee Health**2-201.11C**

**** Priority 1 ****

MN Rule 4626.0040C The person in charge must record all reports of diarrhea or vomiting made by food employees and report those illnesses to the regulatory authority at the specific request of the regulatory authority.

ESTABLISHMENT DOES NOT HAVE AN EMPLOYEE ILLNESS LOG. MDH LOG FORM SENT WITH REPORT. EXCLUSION AND LOGGING REQUIREMENTS REVIEWED DURING INSPECTION.

Comply By: 07/09/24

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.

UNPASTEURIZED SHELL EGGS STORED ABOVE READY-TO-EAT FOODS IN THE REFRIGERATOR. CORRECTED ON SITE. EGGS WERE MOVED TO BOTTOM DRAWER IN REFRIGERATOR DURING INSPECTION.

Comply By: 07/09/24

3-500C Microbial Control: date marking**3-501.17B**

**** Priority 2 ****

MN Rule 4626.0400B Mark the refrigerated, ready-to-eat, TCS food prepared and packaged in a processing plant and opened and held for more than 24 hours in the food establishment using an effective method to indicate the date by which the food must be consumed on the premises, sold, or discarded. The date must not exceed the manufacturer's use-by-date.

MILK AND DELI MEAT IN THE KITCHEN REFRIGERATOR THAT WERE OPENED MORE THAN

Type: Full
Date: 07/09/24
Time: 11:00:00
Report: 8041241125
Merrcy Care Home Llc

Food and Beverage Establishment Inspection Report

Page 2

24 HOURS AGO NOT DATE MARKED. CORRECTED ON SITE. DATE MARKING REQUIREMENTS REVIEWED DURING INSPECTION.

Comply By: 07/09/24

2-100 Supervision

2-102.12DMN

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

CERTIFIED FOOD PROTECTION MANAGER CERTIFICATE IS NOT POSTED ON SITE.

Comply By: 07/16/24

4-500 Equipment Maintenance and Operation

4-501.11AB

MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.

THE BOTTOM INTERIOR OF THE MICROWAVE IS DAMAGED. ESTABLISHMENT IS LOOKING FOR A REPLACEMENT.

Comply By: 08/10/24

Food and Equipment Temperatures

Process/Item: Cold Holding

Temperature: 40 Degrees Fahrenheit - Location: kitchen refrigerator: yogurt

Violation Issued: No

Process/Item: Cold Holding

Temperature: 38 Degrees Fahrenheit - Location: kitchen refrigerator: turkey

Violation Issued: No

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

Inspection was completed with Burham Daynab. Wendy Buckholz was the lead Health Regulation Division Nurse Evaluator. Facility had four residents on site at time of inspection.

This establishment has a residential kitchen. Food must be prepared for same day service only. The kitchen has wood cabinets with a hollow base, solid surface countertop and vinyl tile flooring.

A two basin sink is located in the kitchen with one basin designated for handwashing. Establishment has a Whirlpool dishwasher that has a sani rinse/high temp cycle. Dishwasher achieved a utensil surface temp. of at least 160F for sanitizing dishes.

Discussed the following:

- Employee illness policy and logging requirements
- Handwashing
- Glove-use and bare hand contact
- Pest control
- Food storage and preventing cross contamination
- Date marking
- Restrictions concerning serving a highly susceptible population
- Vomit clean up process

Type: Full
Date: 07/09/24
Time: 11:00:00
Report: 8041241125
Merrcy Care Home Llc

Food and Beverage Establishment Inspection Report

Page 3

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 8041241125 of 07/09/24.

Certified Food Protection Manager Idris Abdi

Certification Number: fm107897 Expires: 09/27/24

Inspection report reviewed with person in charge and emailed.

Signed: _____

Burham Daynab
Manager/owner

Signed: 

Sarah Conboy
Public Health San. Supervisor
651-201-3984
sarah.conboy@state.mn.us