



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

September 13, 2023

Licensee
Mainstreet Village
7601 Lyndale Avenue South
Richfield, MN 55423

RE: Project Number(s) SL21184015

Dear Licensee:

On September 6, 2023, 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 June 28, 2023. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the June 28, 2023 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey completed on June 28, 2023, found not corrected at the time of the September 6, 2023, follow-up survey and/or subject to penalty assessment are as follows:

2310-Appropriate Care And Services-144g.91 Subd. 4 (a)

The details of the violations noted at the time of this follow-up survey completed on September 6, 2023 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

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

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 the MDH within 15 calendar days of the correction order receipt date.

A state correction order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

Please email reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

Please address your cover letter for reconsideration requests to:

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

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

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

Sincerely,



Casey DeVries, Supervisor
State Evaluation Team
Email: casey.devries@state.mn.us
Telephone: 651-201-5917 Fax: 651-281-9796

PMB

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 21184	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 09/06/2023
NAME OF PROVIDER OR SUPPLIER MAINSTREET VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 7601 LYNDAL AVENUE SOUTH RICHFIELD, MN 55423			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
{0 000}	Initial Comments *****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: SL21184015-1 On September 6, 2023, the Minnesota Department of Health conducted a revisit at the above provider, and the following correction order is re-issued. At the time of the survey, there were 49 residents; all of whom received services under the provider's Assisted Living Facility with Dementia Care license.	{0 000}	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.		
{0 480} SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the	{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 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: No further action taken.	{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: No further action taken.	{0 650}			

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{0 730} SS=F	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and	{0 730}			

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{0 730}	Continued From page 3 any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: No further action taken.	{0 730}			
{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: No further action taken.	{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	{0 810}			

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{0 810}	Continued From page 4 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: No further action taken.	{0 810}			
{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	{01640}			

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{01640}	Continued From page 5 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, 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: No further action taken.	{01640}			
{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	{01650}			

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{01650}	Continued From page 6 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: No further action taken.	{01650}			
{01880} SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: No further action taken.	{01880}			
{01890} SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug.	{01890}			

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{01890}	Continued From page 7	{01890}			
{02090} SS=E	144G.82 Subdivision 1 General This MN Requirement is not met as evidenced by: No further action taken. The licensee of an assisted living facility with dementia care is responsible for the care and housing of the persons with dementia and the provision of person-centered care that promotes each resident's dignity, independence, and comfort. This includes the supervision, training, and overall conduct of the staff. This MN Requirement is not met as evidenced by: No further action taken.	{02090}			
{02110} SS=C	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an	{02110}			

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{02110}	Continued From page 8 assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in. This MN Requirement is not met as evidenced by: No further action taken.	{02110}			
{02170} SS=F	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following: (1) past and current interests; (2) current abilities and skills; (3) emotional and social needs and patterns; (4) physical abilities and limitations; (5) adaptations necessary for the resident to participate; and (6) identification of activities for behavioral interventions. (c) An individualized activity plan must be	{02170}			

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{02170}	Continued From page 9 developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs. (d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to: (1) occupation or chore related tasks; (2) scheduled and planned events such as entertainment or outings; (3) spontaneous activities for enjoyment or those that may help defuse a behavior; (4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music; (5) spiritual, creative, and intellectual activities; (6) sensory stimulation activities; (7) physical activities that enhance or maintain a resident's ability to ambulate or move; and (8) outdoor activities. This MN Requirement is not met as evidenced by: No further action taken.	{02170}			
{02310} SS=D	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	{02310}			

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{02310}	Continued From page 10 review, the licensee failed to provide care and services according to acceptable health care, medical or nursing standards for one of six residents (R13) who utilized hospital bed rails. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: On September 6, 2023, at 7:51 a.m., the Minnesota Department of Health (MDH) initiated an offsite (desk) revisit to assess the licensee's plan of correction (POC) in response to an immediate order issued during a routine survey on June 26, 2023. The licensee's clinical nurse supervisor ((CNS)-A) provided requested documentation via email. R13 was admitted to the licensee on August 21, 2021. R13's Hospital Return Clinical Update Assessment dated July 13, 2023, indicated R13 had a hospital bed which included half rails (bed rails) to assist resident with independence with transfers and bed mobility. R13's Bed Rail Assessment dated July 13, 2023, indicated R13 utilized their bed rails to aid the resident with transfers and bed mobility. R13's Bed System Device Assessment Test Results Worksheet, dated July 25, 2023,	{02310}			

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{02310}	Continued From page 11 indicated zones of entrapment with a Pass/Fail (P/F) option to be circled by the staff member conducting the measurements for the Food and Drug Administration (FDA) measurement requirements. The assessment had a P circled (pass) for zones 1, 2, 3, 4 and 7, but lacked documentation of what the measurements were. On September 6, 2023, at 11:26 a.m., CNS-A's email indicated, "I spoke with Maintenance due to they conduct the measurements and fill out the form. While talking with the Maintenance team they do the measurements and that is where the Pass or fail comes from. I also spoke with the regional director of clinical and he also told me that this is the process. There is a box on the assessment on the side that talks about the zones and what the measurements are supposed to be." On September 6, 2023, at 11:52 a.m., CNS-A stated they understood the need for exact measurements documentation requirements and would adjust their documentation requirements and policy to address the issue. The FDA's, A Guide to Bed Safety, dated 2000, and revised April 2010, indicated following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe."	{02310}			

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{02310}	Continued From page 12 The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, "Documentation about a resident's bed rails includes, but is not limited to: - Purpose and intention of the bed rail; - Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail; - The resident's bed rail use/need assessment; - Risk vs. benefits discussion (individualized to each resident's risks); - The resident's preferences; - Installation and use according to manufacturer's guidelines; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements". Additionally, the MDH website indicated for hospital-style bed rails, the licensee must include in their documentation, the bed rail measurements and that the bed rail has not shifted and is securely attached to the bed frame per manufacturer recommendations.	{02310}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 21184	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 09/06/2023
NAME OF PROVIDER OR SUPPLIER MAINSTREET VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 7601 LYNDALE AVENUE SOUTH RICHFIELD, MN 55423		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
{02310}	Continued From page 13 The licensee's Physical Device Assessment Policy dated November 2022, indicated: "1. Upon admission, with significant change, annually or the implementation of a new device, the resident will be assessed for physical devices. The assessment will be reviewed quarterly. The assessment includes but is not limited to: an assessment of symptoms, ability to use the device, and potential risk and benefit. 2. Once the assessment is completed an appropriate device is selected if determined appropriate by the interdisciplinary team. 3. The date of initiation of the physical device will be noted on the assessment. 4. The medical symptoms will be reviewed and included in the assessment. 5. Alternatives to the physical device that have been attempted or are currently being used will be listed. The least restrictive means of providing assistance will be recommended. 6. Specific time frames will be included as to when the physical device will be used. 7. Benefits and risks of the physical device will be listed. 8. The following criteria will be met as consistent with Federal regulation as specified under F 700 of the OBRA requirements. a. Any device that is attached to the bed, or fixed adjacent to the bed is defined as a "bed assist device" and additionally as defined in the guidance will follow the criteria for "side rails". b. The device will not be placed until after an attempt without the bed assistive device is trialed. This trial will be documented on the assessment. c. The facility must also attempt to use appropriate alternatives to bed rails and determine that those alternatives do not meet the resident's needs.	{02310}			

Minnesota Department of Health

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{02310}	Continued From page 14 d. Prior to application of the device, the assessment for the device will be documented and will include: 1. Medical reason why the device is needed, devices are not applied to the bed for safety purposes. The device must be used by the resident to enhance or maintain mobility. 2. Risks of entrapment or injury based on the following factors: (a) Communication abilities (b) Cognition/presence of delirium or behaviors (c) Weight, height or body type of the resident (d) Mobility of the resident (e) Acute medical or surgical needs of the resident (f) Sleep habits 3. The facility will maintain documentation that sufficient information was provided so that the resident or resident representative could make an informed consent. Information that the facility should provide to the resident or resident representative in the documented informed consent will be: (1) The assessed medical needs that would be addressed by use of the bed rail(s) (2) Resident's benefit from the use of the bed rail(s) (3) Resident's risk with use of the bed rail(s) and how these risks will be mitigated (4) Alternatives attempted that failed to mee the resident's needs and alternatives considered but not attempted because they were considered 4. Documented verbal consent is required prior to application of the device at a minimum, but a signed consent will be maintained in the medical record. e. Engineering will be contacted to apply the	{02310}			

Minnesota Department of Health

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{02310}	Continued From page 15 device. (See Mattress, Bed Frame and Assist 9. The plan of care will be updated to reflect the selection of the devices identified. * See also Physical Restraint Policy and Mattress, Bed Frame and Assistive Device Selection ,and Inspection Policy" No further information provided. TIME PERIOD FOR CORRECTION: Two (2) days	{02310}			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

July 31, 2023

Licensee
Mainstreet Village
7601 Lyndale Avenue South
Richfield, MN 55423

RE: Project Number(s) SL21184015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on June 28, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the 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. The MDH documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

IMPOSITION OF FINES

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

Level 1: no fines or enforcement.

Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;

Level 3: a fine of \$3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.

Level 4: a fine of \$5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5), the MDH may impose fine amounts of either \$1,000 or \$5,000 to licensees who are found to be responsible for maltreatment.

The MDH may impose a fine of \$1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The MDH

also may impose a fine of \$5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

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

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

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

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

A state correction order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

Mainstreet Village

July 31, 2023

Page 3

Please email reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

Please address your cover letter for reconsideration requests to:

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

REQUESTING A HEARING

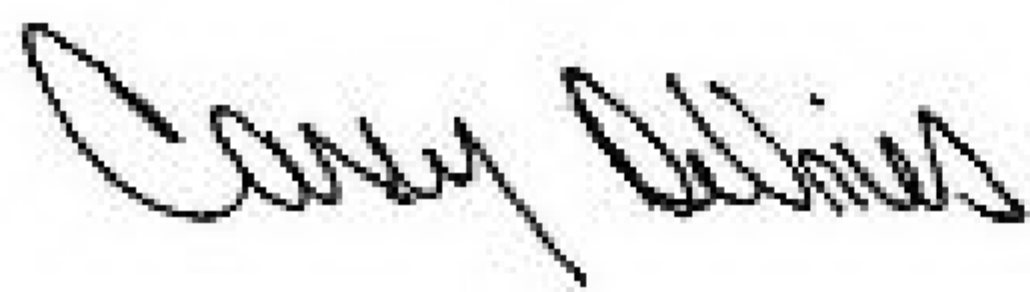
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for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

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.

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

If you have any questions, please contact me.

Sincerely,



Casey DeVries, Supervisor
State Evaluation Team
Email: casey.devries@state.mn.us
Telephone: 651-201-5917 Fax: 651-281-9796

JMD

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 21184	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/28/2023
NAME OF PROVIDER OR SUPPLIER MAINSTREET VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 7601 LYNDAL AVENUE SOUTH RICHFIELD, MN 55423		
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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: SL21184015-0 On June 26, 2023, through June 28, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 48 residents; all of whom received services under the provider's Assisted Living Facility with Dementia Care license. An immediate correction order was issued on June 26, 2023, at approximately 7:45 p.m. The immediacy was removed on June 27, 2023, at approximately 3:00 p.m.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the	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 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 had the potential to affect all residents of the assisted living facility with dementia care. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report, dated June 26, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	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	0 650			

Minnesota Department of Health

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0 650	Continued From page 2 include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee records included all required content for one of two employees (unlicensed personnel (ULP)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include:	0 650			

Minnesota Department of Health

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0 650	Continued From page 3 ULP-B was hired June 18, 2018, and began providing assisted living services on August 1, 2021. On June 26, 2023, at 12:45 p.m., ULP-B was observed to assist R1 with medication administration. ULP-B's employee record included an annual performance review dated July 13, 2020. ULP-B's record lacked documentation of subsequent annual performance reviews to identify areas of improvement needed and training needs. On June 26, 2023, at 6:11 p.m., human resources manager (HR)-I stated there were no more current performance reviews for ULP-B since the one completed in 2020. HR-I further stated the registered nurse (RN) typically completed the annual performance reviews, but ULP-B "must have been missed". No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650			
0 730 SS=F	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service	0 730			

Minnesota Department of Health

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0 730	Continued From page 4 providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	0 730			

Minnesota Department of Health

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0 730	Continued From page 5 review, the licensee failed to ensure the resident record included documentation of all provided services for four of four residents (R1, R2, R6, R10). 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 R1 was admitted June 19, 2023. R1's service plan, dated June 19, 2023, indicated R1 received the following scheduled services: -linen changes: every Monday at 8:00 a.m.; -meals: two meals per day at 8:00 a.m., and 5:00 p.m.; -room tidy and bed making: daily at 10:00 a.m.; -housekeeping: every Wednesday at 10:00 a.m.; and -laundry: every Monday at 8:00 a.m. R1's record lacked documentation indicating the above-listed services were provided, or documentation of why they were not provided. On June 26, 2023, at 12:15 p.m., unlicensed personnel (ULP)-B stated she was not able to see R1 on her task list for electronic documentation, and that R1 was "not on there yet." On June 28, 2023, at 10:20 a.m., R1 stated the licensee assisted her with BG checks, insulin,	0 730		

Minnesota Department of Health

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0 730	Continued From page 6 laundry, meals, and sometimes housekeeping, but she was not sure how often. R2 R2's service plan, dated October 4, 2022, indicated R2 received the following scheduled services: -linen changes: every Wednesday at 11:00 a.m.; -bathing assistance: every Wednesday at 3:00 p.m.; -dressing and grooming assist: two times per day at 9:00 a.m., and 8:00 p.m.; -room tidy and bed making: daily at 11:00 a.m.; -laundry: every Wednesday at 8:00 p.m.; -hourly reassurance checks: daily; and -toileting assistance: up to four times daily at 9:00 a.m., 4:00 p.m., 6:00 p.m., and 4:00 a.m. R2's service received record for June 2023 lacked documentation the following services were provided, or documentation of why they were not provided: -dressing and grooming assist: June 1, 3, 12, 13 at 9:00 a.m., and June 2, 9 at 8:00 p.m.; -room tidy and bed making: June 1, 3, 12, 13 at 11:00 a.m.; -hourly reassurance checks: June 1, 12, 13 at 7:00 a.m., and June 2, 9 at 3:00 p.m.; and -toileting assistance: June 1, 3, 12, 13 at 9:00 a.m., June 2, 9 at 4:00 p.m., and June 2, 9 at 6:00 p.m. On June 28, 2023, at 1:24 p.m., CNS-A stated R2 might have been out of the building during the time of incomplete services documentation (June 1-13, 2023). CNS-A stated if a resident was out of the building, the documentation might have been left empty, but she was not as familiar with the documentation system.	0 730			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 21184	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 06/28/2023
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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
0 730	Continued From page 7 On June 28, 2023, at 2:08 p.m., CNS-A stated R2 was not out of the facility June 1-13, 2023. CNS-A stated there was possibly a problem with the electronic medical record that prevented the documentation from saving, but she could not say for sure. R6 R6's service plan, dated September 27, 2022, indicated R6 received the following scheduled services: -linen changes: every Sunday at 3:00 p.m.; -bathing assistance: every Sunday at 8:00 p.m.; -meals: three meals per day at 8:00 a.m., 11:00 a.m., and 4:00 p.m.; -dressing and grooming assist: two times per day at 8:00 a.m., and 8:00 p.m.; -lotion to legs at bedtime: daily at 8:00 p.m.; -housekeeping: every Sunday and Monday at 8:00 a.m.; -room tidy and bed making: daily at 8:00 a.m.; -laundry: every Sunday at 3:00 p.m.; -hourly reassurance checks: daily; -toileting assistance: up to four times daily at 9:00 a.m., 4:00 p.m., 6:00 p.m., and 4:00 a.m.; -assistance with bed mobility: daily at 8:00 p.m.; -bed mobility 8:00 p.m.; -escort to meals and activities: three times daily at 8:00 a.m., 12:00 p.m., and 4:00 p.m.; and -medication administration 4+ times daily: 8:00 a.m., 12:00 p.m., 4:00 p.m., and 8:00 p.m. R6's service received record for June 2023 lacked documentation the following services were provided, or documentation of why they were not provided: -bathing assistance: June 5, 8, 15, 19 at 8:00 a.m.; -dressing and grooming assist: June 1, 5, 8, 9, 14, 15, 17, 19, 20 at 8:00 a.m., June 3, 7, 9, 11,	0 730			

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0 730	Continued From page 8 13, 14, 17, 18, 21, 23, 25 at 8:00 p.m.; -room tidy and bed making: June 1, 5, 8, 9, 14, 15, 17, 19, 20 at 8:00 a.m.; -laundry: June 5, 19 at 8:00 a.m.; -bed mobility: June 3, 9, 20, 22, 8:00 p.m.; -hearing aid assist: June 3 at 8:00 p.m.; -escort to meals and activities: June 1, 5, 8, 9, 14, 15, 17, 19, 20 at 8:00 a.m., June 1, 4, 5, 8, 9, 14, 15, 17, 19, 20 at 12:00 p.m., and June 3, 9 at 4:00 p.m.; and -medication administration 4+ times daily: June 1, 2, 15, 16, 21, 8:00 a.m., June 2, 7, 15, 16, 21, 23 12:00 p.m., June 11, 25 8:00 p.m. R10 R10's service plan dated April 8, 2022, indicated R10 received the following scheduled services: -morning and evening cares: twice daily at 8:00 a.m. and 7:00 p.m.; -linen changes: every Sunday at 10:00 p.m.; -assistance with compression stockings: twice daily at 8:00 a.m. and 7:00 p.m.; -shower: weekly and as needed every Tuesday at 7:00 p.m.; -hourly safety checks: daily at 10:00 p.m., 11:00 p.m., 12:00 a.m., 1:00 a.m., 2:00 a.m., 3:00 a.m., 4:00 a.m., 5:00 a.m., and 6:00 a.m.; -room tidy and bed making: daily at 8:00 a.m.; -laundry: every Monday at 3:00 p.m.; -escort to meals and activities: three times daily at 8:00 a.m., 12:00 p.m., and 4:30 p.m.; and -toileting assistance: daily at 8:00 a.m., 11:00 a.m., 1:00 p.m., and 7:00 p.m.; R10's service received record for June 2023 lacked documentation the following services were provided, or documentation of why they were not provided: -medication management: June 2 at 8:00 a.m., June 2 at 12:00 p.m.	0 730			

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0 730	Continued From page 9 On June 27, 2023, at 11:23 a.m., observed ULP-N administering medications to R10. On June 28, 2023, at 10:50 a.m., CNS-A stated there should be nothing left blank on the Service Received record even if a service was not provided, if a resident refused a service, or if the resident were on a leave of absence (LOA). The expectation was a reason be documented as to why the service was not provided. The licensee's MN AL Resident Record policy dated March 16, 2023, indicated a resident record would contain, "Documentation that services have been provided as identified in the service plan." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730		
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 physical environment, including walls, floors, ceiling, all furnishings,	0 800		

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0 800	Continued From page 10 grounds, systems, and equipment in a continuous state of good repair and operation regarding the health, safety, comfort, and well-being of the residents. This deficient condition had the ability to affect a limited number of 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) 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 facility tour with the Maintenance Director (MD)-F between approximately 9:00 AM and 12:30 PM on June 28, 2023, it was observed that the trash chute doors on the 1st, 2nd, and 4th floors did not close and positively latch as required as part of the fire rated shaft assembly. This deficient condition was visually verified by MD-F accompanying on the tour. It was also observed that the elevator lobby doors in the garage level were kept in the open position by using wedges. These doors must be kept closed to maintain their fire rating and to provide the necessary protection to the elevator shaft. This deficient condition was visually verified by MD-F accompanying on the tour. It was also observed that scissors were kept in an unsecured drawer in the kitchen of the memory care unit of the facility. Dangerous utensils and other items are required to be kept in a secured area in the memory care unit. This deficient condition was visually verified by MD-F	0 800			

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0 800	Continued From page 11 accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (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	0 810		

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0 810	Continued From page 12 drill. This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to provide required employee training on fire safety and evacuation. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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: A record review and interview were conducted on June 28, 2023, between approximately 12:30 p.m. and 1:25 p.m. with the Maintenance Director (MD)-F and the Licensed Assisted Living Director (LALD)-D on the fire safety and evacuation plan, fire safety and evacuation training for the facility, and fire safety and evacuation drills for the facility. Record review indicated that employees did not receive training twice per year after initial hire. During interview, LALD-D and MD-F stated they misunderstood the requirement and believed that training was only required once per year after hire. This deficient condition was verified by LALD-D and MD-F during the interview. TIME PERIOD FOR CORRECTION: Twenty-one	0 810			

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0 810	Continued From page 13 (21) days	0 810		
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, 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 have a current signed service plan which identified specific services to be provided for two of six residents (R3, R12). 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	01640		

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01640	Continued From page 14 resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R3 R3 was admitted to the licensee on February 17, 2023. R3's Service Agreement/Plan dated March 8, 2023, indicated R3 received services for housekeeping, laundry, behavior management, morning and evening cares, shower one time per week, and medication management. R12 R12 was admitted to the licensee on August 23, 2022. R12's Service Agreement/Plan dated August 23, 2022, indicated R12 received services for medication management, meals, linen service, and laundry. R3 and R12's Service Agreement/Plan's both lacked grooming services. On June 26, 2023, at 12:02 p.m., the surveyor observed R3 and R12 in the dining room waiting for their lunch to be served. R3 had facial hair with a "goatee" coverage around her mouth approximately 1/4 to 1/2 inches (in.) in length. R12 had sparse facial hair growth with multiple single hairs approximately 1 in. in length on their chin. On June 27, 2023, at 11:49 a.m., unlicensed	01640			

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01640	Continued From page 15 personnel (ULP)-P stated they did shave facial hair for R3 and R12 regularly. ULP-P stated neither of them had facial hair at the time of the interview. Surveyor told ULP-P to go and look at them again, ULP-P stated, "I guess it is long now." ULP-P stated facial hair is only cut when residents receive a bath or shower. On June 28, 2023, at 7:40 a.m., the surveyor observed R3 and R12's facial hair had been shaved off since the day prior. On June 28, 2023, at 10:20 a.m., interviewed family member (FM)-O who stated R3 would have been, "devastated" if they saw they had facial hair. FM-O stated they had noticed it being long on many occasions and if R3 were able to see themselves in the mirror they would have been, "horrified." FM-O stated shaving R3 one time per week wasn't enough. On June 28, 2023, at 10:50 a.m., clinical nurse supervisor (CNS)-A stated R3's grooming was included under the morning and evening cares on the service plan but was not specifically identified as being included in those cares. They agreed facial hair grooming should be specifically identified on R3 and R12's service plan and agreed a one-time per week frequency of facial hair cutting was not enough. CNS-A stated R3 and R12's service plans should identify what needed to be done specifically for the morning and evening cares. CNS-A stated many resident charts were a mess and they had been trying to go through service plans since they were hired to make sure they were accurate but was taking time to get through them all. The licensee's MN AL Service Plan Policy dated August 1, 2021, indicated, "All assisted living	01640			

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01640	Continued From page 16 residents have an up-to-date service plan identifying services to be provided based on the assessment by the RN and/or other licensed health professional." Additionally, it indicated service plans would include, "a description of the services provided." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01640		
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	01650		

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01650	Continued From page 17 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 the resident service plan included the required content for four of four residents (R1, R2, R6, R10). 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's service plan, dated June 19, 2023, indicated R1 received services including assistance with blood glucose monitoring, meals, housekeeping, and laundry. R2's service plan, dated October 4, 2022, indicated R2 received services including assistance with medication management, activities of daily living (ADLs), toileting and laundry. R10's service plan dated April 8, 2022, indicated R10 received services including assistance with medication management, compression stockings, ADLs, showers, toileting, housekeeping, and laundry.	01650			

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01650	Continued From page 18 R1, R2, and R10's service plans all lacked the following: -the methods of monitoring assessments of the resident; and -the schedule and methods of monitoring staff providing services. R6's service plan, dated September 27, 2022, indicated R6 received services including assistance with medication management, ADLs, bathing, meals, housekeeping, and laundry. R6's service plan lacked the following: -the schedule and methods of monitoring assessments of the resident; and -the schedule and methods of monitoring staff providing services. On June 28, 2023, at 11:16 a.m., clinical nurse supervisor (CNS)-A stated they entered the residents' services into the electronic medical record (EMR) to develop the service plan, and the EMR transferred the information into a format that should have included the required elements. CNS-A stated they were planning to transition to another EMR platform and would need to ensure the correct elements were present in that form. The licensee's MN AL Service Plan Policy dated August 1, 2021, indicated, "Service plans will include: a. A description of the services provided b. Fees for services c. Frequency of each service according to resident assessment and resident preferences d. Schedule and methods of monitoring assessments e. Schedule and methods of monitoring staff providing services f. Contingency plan	01650			

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01650	Continued From page 19 g. A contingency plan that includes: i. Action taken if the scheduled service cannot be provided ii. Information and method to contact the facility iii. Names and contact information of persons the resident wishes to have notified in an emergency iv. Names and contact information of persons the resident wishes to have notified if there is a significant adverse change in the resident's condition v. Identification of and information on who has authority to sign for the resident in an emergency vi. Circumstances in which emergency medical services are not to be summoned. This is indicated by reference in the service plan to any legal advanced directives, POLST form, or Living Will documents. Emergency personnel will be contacted as per indicated on the signed service plan in the event of emergency. However, the resident's wishes for emergency medical services will be administered as ordered and in compliance with the resident wishes." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01650			
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access.	01880			

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01880	Continued From page 20 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to monitor the temperature of their medication storage refrigerator to ensure required medications were stored according to manufacturer directions for four of four residents (R1, R6, R13, R14). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On June 26, 2023, at 12:30 p.m., the surveyor observed the facilities medication refrigerator with licensed practical nurse (LPN)-C. The medication refrigerator was not locked but was behind a locked door. It had a vertical classic thermometer which read 42 degrees Fahrenheit (F). There was a stack of approximately 25 Temperature Logs in a manila folder on top of the refrigerator which included the most recent logs from February, March and April 2023. The folder lacked Temperature Logs for the months of May and June 2023. LPN-C stated the medication refrigerator was supposed to be checked and logged on a daily basis. The medication refrigerator contained the following medications: -R1 Humalog KwikPen 100 units/milliliter (u/ml) insulin, five boxes of four pens; -R1 Basaglar KwikPen 100u/ml insulin, expiration October 1, 2024, three boxes of four pens;	01880			

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01880	Continued From page 21 -R6 Calcitonin Salmon nasal spray 200u, Apotex (manufacturer), one bottle; -R13 Lantus SoloStar injection pen 100 u/ml insulin, expiration date December 23, 2023, one pen; -R13 Trulicity 1.5 milligrams (mg)/0.5ml pen injector, expiration date January 15, 2025, box contained four single dose pens; -R13 Lispro KwikPen 100u/ml insulin, expiration September 14, 2025, four pens; and -R14 latanoprost 0.005% eye drops bottle 125 micrograms (mcg)/2.5ml solution, expiration date February 2025, one bottle. On June 27, 2023, at 11:17 a.m., LPN-C stated nurses and unlicensed personnel (ULP) were allowed to record the medication refrigerator temperatures, but no one was assigned to do it. The surveyor questioned how anyone would know if they were supposed to check the temperature if no one was assigned to do it, LPN-C stated, "that's a good point," and that someone needed to be assigned to the task for it to be done consistently. LPN-C provided a medication refrigerator temperature log they created yesterday, June 26, 2023, which had a temperature filled in for the same date. On June 27, 2023, 1:10 p.m. clinical nurse supervisor (CNS)-A stated they did not have a policy to address medication refrigerator monitoring. CNS-A stated they've had so much turnover with staff the medication refrigerator logs had not been getting completed. CNS-A stated the temperature logs found by the surveyor were the only temperature logs they had. Manufacturer directions for latanoprost 0.005% eye drops dated September 16, 2014, indicated unopened bottles should be stored under	01880		

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01880	Continued From page 22 refrigeration at 2 degrees (°) Celsius (C) to 8°C (36° Fahrenheit (F) to 46°F). Manufacturer directions for Calcitonin Salmon (synthetic origin) Nasal Spray revised November, 2017, indicated to store unopened bottles of Calcitonin Salmon (synthetic origin) Nasal Spray in the refrigerator between 36°F to 46°F. Do not freeze. Manufacturer directions for Humalog KwikPen insulin revised April 2020, indicated unopened Humalog should be stored in a refrigerator at 36° to 46°F, but not in the freezer. Manufacturer directions for Lantus SoloStar injection pen revised December 2020, indicated unopened pens could be stored refrigerated 36°F to 42°F until the expiration date. Manufacturer directions for Basaglar KwikPen insulin revised November 2022, indicated to store unused pens in the refrigerator at 36°F to 46°F. Do not freeze Basaglar and do not use if it has been frozen. Manufacturer directions for Trulicity pen injector revised December 2022, indicated, "Store TRULICITY in the refrigerator at 36°F to 46°F. If needed, each single-dose pen can be kept at room temperature, not to exceed 86°F for a total of 14 days. Do not freeze TRULICITY. Do not use TRULICITY if it has been frozen." Manufacturer directions for Lispro KwikPen insulin revised February 12, 2020, indicated to store unused pens in the refrigerator at 36° to 46°F. Do not freeze and do not use if it has been frozen.	01880			

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01880	Continued From page 23 The licensee's AL Medication Management Policy dated June 6, 2023, indicated, "Medications requiring refrigeration are in a locked medication refrigerator in the locked medication room." No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880			
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 medications included required patient identifying labels and medication administration instructions for one of four residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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:	01890			

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01890	Continued From page 24 R1 was admitted to the licensee on June 19, 2023. R1's Service Agreement/Plan dated June 19, 2023, indicated R1 received services including assistance with blood glucose monitoring, meals, housekeeping, and laundry. R1's Medication Management Plan dated June 19, 2023, indicated R1 received assistance with insulin administration. R1's medication administration record (MAR) for June 2023, indicated the licensee assisted R1 with Humalog (insulin lispro-a short acting insulin for diabetes) administration daily from June 20-27, 2023. R1's medication orders signed June 14, 2023, included the following medication: -Humalog 100 units (u)/milliliter (ml) KwikPen insulin, inject three times per day on a sliding scale for diabetes mellitus type two (DM2): 3u for blood glucose (BG) 150-200, 6u for BG 201-250, 9u for BG 251-300, 12u for BG 301-350, 15u for BG 351-400, and for BG greater than 401 call provider. Do not give at bedtime. On June 26, 2023, at 11:39 a.m., unlicensed personnel (ULP)-B stated insulin pens were normally stored in a bag that had the resident's information on it. ULP-B notified licensed practical nurse (LPN)-C the insulin pen for R1 was not labeled with the resident's information. On June 26, 2023, at 12:30 p.m., observed the medication refrigerator with LPN-C which included a Ziploc plastic bag labeled with black magic marker, "[R1] # [room number]." The Ziploc bag included two Humalog 100u KwikPens which	01890			

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01890	Continued From page 25 lacked a pharmacy label or resident identifying information. LPN-C stated the two KwikPens were found in R1's refrigerator in their apartment and must have been put there by the family. On June 26, 2023, at 12:45 p.m., observed R1's Humalog 100u KwikPen stored in the medication cart in a plastic Ziploc bag without a pharmacy label. The KwikPen was labeled with an opened-on date of June 21, 2023. The Ziploc bag had three pieces of paper taped to it which indicated R1's name, room number and, "6/19/12 Insulin Lispro 100unit/ml SOLN - Three Times per day - IJ - ALSO KNOWN AS HUMALOG - INJECT PER BLOOD SUGAR SLIDING SCALE (3u for blood glucose (BG) 150-200, 6u for BG 201-250, 9u for BG 251-300, 12u for BG 301-350, 15u for BG 351-400, and for BG greater than 401 call provider. Do not give at bedtime. - 8AM, 11:30AM, 4:30PM - Indicated for DM2." The KwikPen lacked a pharmacy label or labeling of any kind which would identify the KwikPen as belonging to R1. ULP-B stated they could not locate a pharmacy label for the KwikPen. On June 27, 2023, at 11:17 a.m., LPN-C stated R1 was an after-hours admission and the ULPs must have just stuffed the KwikPen into the medication cart. LPN-C stated they had printed off and applied the Ziploc bag labels yesterday, June 26, 2023, after ULP-B notified the licensee the bag lacked identifying labels. LPN-C stated the two KwikPens for R1 located in the medication refrigerator on June 26, 2023, at 12:30 p.m., were determined to be empty and were discarded. On June 28, 2023, at 10:50 a.m., clinical nurse supervisor (CNS)-A stated a medication should never be without a pharmacy label and should	01890			

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01890	Continued From page 26 have been addressed on admission. CNS-A was unsure why it was not completed. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890			
02090 SS=E	144G.82 Subdivision 1 General The licensee of an assisted living facility with dementia care is responsible for the care and housing of the persons with dementia and the provision of person-centered care that promotes each resident's dignity, independence, and comfort. This includes the supervision, training, and overall conduct of the staff. This MN Requirement is not met as evidenced by: Based on observation, record review and interview, the licensee failed to maintain dignified grooming for three of seven residents (R3, R4, R12). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R3 R3's Service Agreement/Plan dated April 1, 2022,	02090			

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02090	Continued From page 27 indicated R3 received services for medication management, morning and evening cares, linen services, and a shower one time per week. R3's service plan lacked grooming services. R4 R4's Service Agreement/Plan dated February 11, 2022, indicated R4 received services for medication management, bathing assistance, dressing and grooming assistance, laundry, and toileting. R12 R12's Service Agreement/Plan dated August 23, 2022, indicated R12 received services for medication management, housekeeping, laundry, and linen services. On June 26, 2023, at 12:02 p.m., the surveyor observed R3, R4 and R12 in the dining room waiting for their lunch to be served. R3 had facial hair with "goatee" coverage around her mouth approximately 1/4 to 1/2 inches (in.) in length. R4 and R12 had sparse facial hair growth with multiple single hairs approximately 1 in. in length on their chin areas. On June 27, 2023, at 11:49 a.m., unlicensed personnel (ULP)-P stated they did shave facial hair for R3, R4 and R12. ULP-P stated none of them had facial hair at the time of the interview. Surveyor told ULP-P to go and look at all three of them, ULP-P did and stated, "I guess it is long now." ULP-P stated facial hair is only cut when residents receive a bath or shower. On June 28, 2023, at 7:40 a.m., the surveyor observed R3, R4, and R12 and all three had their facial hair removed.	02090			

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02090	Continued From page 28 On June 28, 2023, at 10:20 a.m., interviewed family member (FM)-O stated R3 would have been, "devastated" if she saw they had facial hair. FM-O stated they had noticed it being long on many occasions and if R3 were able to see themselves in the mirror they would have been, "horrified." FM-O stated shaving R3 one time per week wasn't enough. On June 28, 2023, at 10:50 a.m., clinical nurse supervisor (CNS)-A stated grooming was included under the morning and evening cares on the service plan. They agreed a one-time per week frequency of facial hair cutting is not enough and should be identified on the service plan under grooming and/or bathing to ensure it was done. CNS-A stated they were in the process of transitioning to RTask (charting software) which would provide more options and allow them to improve their service plans and implementation. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	02090			
02110 SS=C	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented;	02110			

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02110	Continued From page 29 (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the ten policies and procedures for assisted living with dementia care (ALFDC) were provided to residents and/or the residents' legal and designated representatives for four of four residents (R1, R2, R6, R10). 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	02110			

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02110	Continued From page 30 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: R1 R1 was admitted to the licensee on June 19, 2023, with a diagnosis of diabetes. R2 R2 was admitted to the licensee on September 15, 2018, with a diagnosis of dementia. R6 R6 was admitted to the licensee on September 27, 2022, with a diagnosis of dementia. R10 R10 was admitted to the licensee on December 16, 2019, with a diagnosis of short-term memory loss. R1, R2, R6 and R10's records lacked evidence the licensee provided the resident or residents' designated representative with the required policies and procedures for the ALFDC license. On June 28, 2023, at 12:17 p.m., licensed assisted living director (LALD)-D stated they were unsure of where the ten required dementia care policies were and thought they might be in the welcome packet. LALD-D stated they would also look for documented proof the dementia policies were provided to the resident or their legal designated representative. On June 28, 2023, at 12:47 p.m., housing and marketing councilor (HMC)-Q provided an	02110			

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02110	Continued From page 31 admission packet and stated they did not find the dementia care policies there. On June 28, 2023, at 2:05 p.m., HMC-Q stated they were unable to locate any documentation dementia care policies had been provided. On June 28, 2023, at 2:08 p.m., clinical nurse supervisor (CNS)-A stated they were unable to find documentation of the ten dementia policies being provided to their residents or their designated representatives when they were admitted and the licensee was unaware of the requirement. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02110			
02170 SS=F	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following: (1) past and current interests; (2) current abilities and skills; (3) emotional and social needs and patterns; (4) physical abilities and limitations; (5) adaptations necessary for the resident to participate; and (6) identification of activities for behavioral interventions. (c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs.	02170			

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02170	Continued From page 32 (d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to: (1) occupation or chore related tasks; (2) scheduled and planned events such as entertainment or outings; (3) spontaneous activities for enjoyment or those that may help defuse a behavior; (4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music; (5) spiritual, creative, and intellectual activities; (6) sensory stimulation activities; (7) physical activities that enhance or maintain a resident's ability to ambulate or move; and (8) outdoor activities. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individualized activities and preferences plan contained all required content for three of four residents (R2, R6, R10). 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: R2	02170		

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02170	Continued From page 33 R2 was admitted to the licensee on September 15, 2018, with a diagnosis of Alzheimer's with dementia. R6 R6 was admitted to the licensee on September 27, 2022, with a diagnosis of dementia. R10 R10 was admitted to the licensee on December 16, 2019, with a diagnosis of short-term memory loss and resided in memory care. R10's Activity Questionnaire (4 of 5 pages) dated March 20, 2023, included activity preferences circled from a list of options but did not include a plan to implement the activities. R2, R6, and R10's records lacked an individualized activities and preferences plan to include: -current abilities and skills; -comprehensive past interests list; -current abilities and skills; -emotional and social needs; -necessary adaptation for the resident to participate; -occupational or chore related task; -scheduled and planned events; -spontaneous activities for enjoyment to help defuse behavior; -sensory stimulation activities; -outdoor activities; -physical activity and physical limitations; and -behavioral interventions. On June 28, 2023, at 2:08 p.m., clinical nurse supervisor (CNS)-A stated they had activity logs they could provide from their activities director but did not have individualized plans for any of their	02170		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 21184	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 06/28/2023
NAME OF PROVIDER OR SUPPLIER MAINSTREET VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 7601 LYNDAL AVENUE SOUTH RICHFIELD, MN 55423			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
02170	Continued From page 34 residents as they were unaware of the requirement. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02170			
02310 SS=I	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care, medical or nursing standards for six of six residents (R2, R6, R7, R8, R9, R10) who utilized consumer bed rails. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). This practice resulted in an immediate correction order on June 26, 2023, at approximately 7:45 p.m.	02310	On June 27, 2023, the immediacy of correction order 2310 was removed, however non-compliance remained at a scope and level of I.		

Minnesota Department of Health

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02310	Continued From page 35 The findings include: On June 26, 2023, the licensee provided surveyor with undated document titled, Current Resident Roster, a Minnesota Department of Health template. R2 was the only resident identified to have a bed rail on the provided facility roster. R2 R2 was admitted to the licensee on September 15, 2018. R2's registered nurse (RN) assessment dated April 3, 2023, indicated R2 received services for medication administration, toileting, bathing, dressing, grooming, housekeeping, and laundry. R2's resident record included a Bed Rail Assessment form dated March 23, 2023. The assessment indicated a bed rail was used per family request, to assist R2 with bed mobility. The assessment indicated alternatives were discussed, but did not identify risk versus benefit education provided to the family, or documentation of manufacturer installation guidelines and a review of recalls of the device. R6 R6 was admitted to the licensee on September 27, 2022. R6's RN assessment dated May 15, 2023, indicated R6 received services for medication management, bathing, meals, housekeeping, and laundry. R6's RN assessments dated May 15, 2023, and February 24, 2023, indicated R6 was independent with bed mobility and did not identify any assistive devices for bed mobility. R6's record lacked identification or assessment of any bed mobility device.	02310			

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02310	Continued From page 36 R7 R7 was admitted to the licensee on August 20, 2021. R7's RN assessments, dated February 27, 2023, and May 22, 2023, indicated R7 had a "side rail/ bed rail" used for bed mobility. R7's lacked assessment of the device. In addition, R7's record lacked documentation that alternatives were discussed, did not identify risk versus benefit education provided to the family, or documentation of manufacturer installation guidelines and a review of recalls of the device. R8 R8 was admitted to the licensee on November 22, 2019. R8's RN assessment, completed March 31, 2023, did not indicate a bed rail or bed mobility assistive device being used by R8. R8's record lacked identification or assessment of any bed mobility device. R9 R9 was admitted to the licensee on June 1, 2019. R9's RN assessments dated February 27, 2023, and May 22, 2023, indicated R9 was independent with bed mobility and did not identify any assistive devices for bed mobility. R9's record lacked identification or assessment of any bed mobility device. R10 and R11, a married couple, were both admitted to the licensee on December 16, 2019. R10's RN assessments dated March 20, 2023, and June 7, 2023, indicated R10 was independent with bed mobility and had a "side	02310		

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02310	Continued From page 37 rail/ bed rail" used for bed mobility. R10's record lacked assessment of the device. In addition, R10's record lacked documentation that alternatives were discussed, did not identify risk versus benefit education provided to the family, or documentation of manufacturer installation guidelines and a review of recalls of the device. On June 26, 2023, the licensee provided surveyor with undated document titled, Current Resident Roster, a Minnesota Department of Health template. R2 was the only resident identified to have a bed rail on the provided facility roster. The licensee's roster indicated R7 received medication administration and oxygen therapy, R8 received medication administration, R9 received medication administration, and R10 received medication administration. The roster indicated R11 received housing only. On June 26, 2023, at 1:42 p.m., R6 and her family member (FM)-E stated on June 26, 2023, (date of survey) the licensee came and removed R6's bed rail which they had on R6's bed since she moved into the facility. FM-E stated they were told by the facility's maintenance personnel it did not meet safety requirements. R6 and FM-E reported maintenance removed the bed rail and stated they would work on getting R6 a replacement bed rail. Both R6 and FM-E stated they had not seen staff assess the bed rail since R6 moved in. Immediately following the interview, the surveyor observed a bed rail in R6's closet near the entryway of the apartment. The bed rail was black, with four horizontal bars covered by a black mesh, and had straps to secure it to the bed under the mattress. On June 26, 2023, at 1:51 p.m., R2 stated their bed rails were installed by their family member	02310			

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02310	Continued From page 38 some time ago. The surveyor observed the bed rails to be black grab bar style rails with one on each side of the bed. R2 stated they were not sure if the bed rails had ever been assessed by the licensee. On June 26, 2023, at 2:03 p.m., clinical nurse supervisor (CNS)-A and vice president/licensed assisted living director (LALD-D) stated they believed there to be two residents who had bed rails. LALD-D stated their maintenance director (MD)-F did a bed rail audit on June 26, 2023, and they believed R6's bed rail was removed at the same time. CNS-A stated, "this is the first I've heard of R6 having a bed rail." CNS-A stated they had completed some of R6's assessments but had not been in R6's room and assessed their bed, specifically. CNS-A stated they had assessed R2's bed rail but was not sure how many times as they had been trying to catch up on bed rails and assessments since they were hired in October 2022. LALD-D stated the licensee offers certain bed rails but stated they were not actual rails, they were grab bar style rails, and the licensee had two styles which they recommend to families. LALD-D stated they do refer to the manufacturer instructions and check to see if the product had been recalled during their installation process. LALD-D stated there should be audits done for bed rails monthly to include checking all rooms in the facility to check if any new bed rails were installed without the licensee's knowledge, but LALD-D acknowledged the audits were not being completed as they should have been. On June 26, 2023, at 2:40 p.m., CNS-A stated they were trying to get assessments to provide from ElderMark (documentation software) but was having computer problems. They provided	02310			

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02310	Continued From page 39 the one assessment for R2 from March 23, 2023, and stated it was the only assessment found so far. Later at 2:57 p.m., CNS-A stated R2's bed rail assessment from March 23, 2023, was the only one they could find of any of their residents with bed rails. On June 26, 2023, at 2:57 p.m., CNS-A provided 90-day assessments for R2 and R6, they were unable to find any additional bed rail assessments for any of the other residents. On June 26, 2023, at 3:03 p.m., MD-F stated monthly they were supposed to go room to room looking for new bed rails and to make sure they were installed correctly for both new and old bed rails. MD-F stated they then gave a report to the CNS. MD-F stated the licensee only had two approved bed rails which they would recommend to the residents and families, they stated since they started working at the facility five years ago, they had only installed one bed rail which was for R2. MD-F stated they would provide surveyors with the email correspondence to CNS-A where they reported the monthly bed rail findings. MD-F stated they were told by CNS-A via text message on June 26, 2023, at 10:02 a.m., to remove the bed rails that were found out of compliance; they showed the text message to the surveyor, which identified CNS-A as the sender of the text message, that read, "pull em off," therefore, MD-F did so per the instruction. On June 26, 2023, at 3:21 p.m., MD-F forwarded an email string to the surveyor. The email string indicated on June 8, 2023, at 9:41 a.m., MD-F sent an email to CNS-A and LALD-G which indicated there were six residents with bed rails and outlined the room numbers the residents lived in (rooms identified were for R2, R6, R7, R8,	02310			

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02310	Continued From page 40 R9, and R10). The email string identified the earliest response from any recipients was on June 26, 2023, at 9:39 a.m., from LALD-G, which indicated, "I am reaching out to [R6's] son to let him know that we will be removing," in reference to R6's bed rails. The email had a further exchange between LALD-G, regional registered nurse (RN)-H, and LALD-D which discussed the proper policy and protocol for bed rails at the licensee. On June 26, 2023, at 3:34 p.m., an interview was conducted with approximately seven staff members present. Surveyor asked who gave instruction to MD-F to have the bed rails removed for the residents, there was a long pause and no one answered. LALD-D stated they would assume it came from LALD-G who was not currently there. CNS-A stated LALD-G was the one who emailed them to have the bed rails removed, then CNS-A relayed the information to MD-F via text message, and no nursing assessment was completed prior to the bed rails being removed. CNS-A acknowledged MD-F identified the bed rails on June 8, 2023, but no follow up was completed until June 26, 2023. CNS-A stated they would be completing assessments as soon as possible. CNS-A stated when they first were hired the facility was a "disaster," and had been trying to address things as they came up. Assessments weren't being completed or done correctly, they couldn't tell who had completed assessments or if they were completed in person, the medication carts were filled with medications which were expired, it was really hard to get caught up on things and were basically trying to do a whole, "reset" of the process to get everything on track. The assessments were currently being completed by their part time registered nurse RN-J who was	02310			

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02310	Continued From page 41 hired to help them get back on track. LALD-D, human resources manager (HR)-I, and CNS-A all stated there had been staffing challenges which had made CNS-A's job difficult. On June 26, 2023, at 4:45 p.m., unlicensed personnel (ULP)-K stated room R10 and R11 were a married couple who shared a bed. The surveyor observed no bed rail on the bed. ULP-K stated at one time they had a bed rail on the bathroom side of the double bed but was unsure of who it was for or when it was removed. Neither R10 nor R11 were available for interview. On June 26, 2023, at 6:08 p.m., CNS-A stated they were not sure if it was R10 or R11 who had the bed rails and was working on figuring out who which one of them was through assessment. The Food and Drug Administration's (FDA), A Guide to Bed Safety, dated 2000, and revised April 2010, indicated following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as	02310			

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02310	Continued From page 42 they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, "Documentation about a resident's bed rails includes, but is not limited to: - Purpose and intention of the bed rail; - Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail; - The resident's bed rail use/need assessment; - Risk vs. benefits discussion (individualized to each resident's risks); - The resident's preferences; - Installation and use according to manufacturer's guidelines; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements". Additionally, the MDH website indicated for hospital-style bed rails, the licensee must include in their documentation, the bed rail measurements and that the bed rail has not shifted and is securely attached to the bed frame per manufacturer recommendations. The licensee's AL Physical Device Policy and Procedure updated June 6, 2023, indicated: "The use of any physical device will be reviewed and discussed at or prior to the start of care, with each clinical update (at least every 90 days or with significant change) and with the initiation of a	02310		

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02310	Continued From page 43 new device when facility is made aware, to determine if the device is still needed to enhance the resident ' s safety and/ or bed mobility." "8. Bed Assist Devices: a. Due to the risk of injury related to the use of physical devices, PHS Engineering staff will only assist residents with the installation on bed assistive devices (that are FDA recommended) on personal beds under the following guidelines: i. The resident has been clinically assessed for the appropriate use of the device. ii. The resident and/or responsible party has been educated regarding the risks and benefits of the physical device. iii. The resident and/or responsible party have agreed to the use and installation of the device as intended per manufacturer's recommendations and understand the risks of physical devices. iv. The resident and/or responsible party has agreed to pay for the installation and maintenance of the device by the engineering staff. v. The manufacturer's guidelines have been provided to PHS clinical and engineering staff and when installed device and bed meet FDA requirements for zones of entrapment. vi. During installation, annual review, change in condition and change of assistive device, engineering will physically inspect for areas of entrapment, ensure device meets FDA requirements for zones of entrapment, check the stability of the device and ensure the device is installed per manufacturer ' s guidelines. Annual review will happen in conjunction with routine apartment inspections, which will be triggered through the PHS Tels Work Order System. b. Important to note: Consumer "bed rails" or assistive devices are to be installed per manufacturer guidelines and measurements are not required for consumer "bed rails" or	02310		

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02310	Continued From page 44 consumer beds (non-hospital beds). The PT bed cane and Halo, both PHS recommended devices fall into this category. Documentation for a hospital bed with a rail will contain information regarding zones of entrapment per FDA guidelines. Installation and annual review will be documented on the manufacturer's instructions and on the bed system device assessment test results worksheet in the resident ' s medical record." No further information provided. TIME PERIOD FOR CORRECTION: IMMEDIATE	02310			



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

Type: Full
Date: 06/26/23
Time: 13:00:00
Report: 1013231164

Food and Beverage Establishment Inspection Report

Page 1

Location:

Mainstreet Village
7601 Lyndale Avenue South
Richfield, MN 55423
Hennepin County, 27

Establishment Info:

ID #: 0039234
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6128696584
ID #:

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

The following orders were issued during this inspection.

3-500B Microbial Control: hot and cold holding

3-501.16A2

**** Priority 1 ****

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

COLD TCS FOOD MEASURED ABOVE 41F LOCATED ON THE BOTTOM SHELF OF THE KITCHEN 2-DOOR COOLER: CHICKEN SALAD 52F, CHOPPED LETTUCE 45F. PER STAFF FOOD WAS PREPARED 3 HRS PRIOR. DISCUSSED REFRIGERATOR STOCKING WITH STAFF. FOOD WAS DISCARDED AFTER 4 HRS.

Corrected on Site

3-300C Protection from Contamination: equipment/utensils, consumers

3-304.12E

MN Rule 4626.0275E Store food preparation or dispensing utensils that are used with non-TCS foods, such as ice, in a clean, protected location.

ICE SCOOP WAS STORED INSIDE THE ICE MACHINE WITH THE HANDLE IN CONTACT WITH THE ICE. DISCUSSED UTENSIL STORAGE WITH STAFF AND THE ICE SCOOP WAS MOVED SO THAT THE HANDLE WAS UP AWAY FROM THE ICE.

Corrected on Site

Surface and Equipment Sanitizers

Chlorine: = 100 ppm at Degrees Fahrenheit
Location: Dish machine
Violation Issued: No

Type: Full
Date: 06/26/23
Time: 13:00:00
Report: 1013231164
Mainstreet Village

Food and Beverage Establishment Inspection Report

Page 2

Sink and Surface: = 272,704 at Degrees Fahrenheit
Location: Sanitizer - prep area
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Deli meat
Temperature: 41 Degrees Fahrenheit - Location: Walk-in cooler
Violation Issued: No

Process/Item: Chicken
Temperature: 41 Degrees Fahrenheit - Location: Walk-in cooler
Violation Issued: No

Process/Item: Cheese
Temperature: 40 Degrees Fahrenheit - Location: Assisted living cooler
Violation Issued: No

Process/Item: Milk
Temperature: 38 Degrees Fahrenheit - Location: Assisted living cooler
Violation Issued: No

Process/Item: Burger
Temperature: 154 Degrees Fahrenheit - Location: Steamer
Violation Issued: No

Process/Item: Cheese
Temperature: 40 Degrees Fahrenheit - Location: 2 door cooler - upper shelf
Violation Issued: No

Process/Item: Salad
Temperature: 40 Degrees Fahrenheit - Location: Cold top cooler
Violation Issued: No

Process/Item: Turkey
Temperature: 41 Degrees Fahrenheit - Location: Cold top cooler
Violation Issued: No

Process/Item: Salad dressing
Temperature: 40 Degrees Fahrenheit - Location: Tall cooler
Violation Issued: No

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

The inspection was completed with the operator and reviewed with MDH Nurse Evaluator R. Anderson.

The operator stated their MN CFPM renewal application was recently submitted.

Discussed hand washing, ware washing, staff illness policy, temperature control, final cook temperatures, cleaning, serving highly susceptible populations, sanitizer, food storage, and food handling procedures.

Type: Full
Date: 06/26/23
Time: 13:00:00
Report: 1013231164
Mainstreet Village

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 1013231164 of 06/26/23.

Certified Food Protection Manager Darcy Bogren

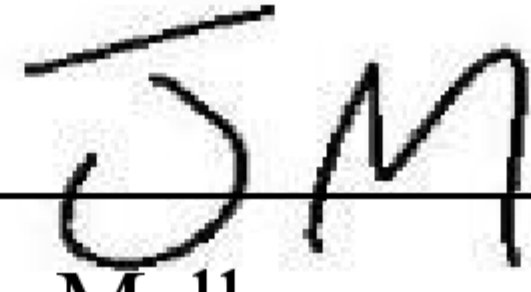
Certification Number: 102743 Expires: 02/06/23

Inspection report reviewed with person in charge and emailed.

Signed: _____

Darcy Bogren
Operator

Signed: _____


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