Electronically Delivered

January 2, 2025

Licensee
Savage Senior Living
5950 West 130th Lane
Savage, MN 55378

RE: Project Number(s) SL31696016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on November 21, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

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

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

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

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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

To submit a hearing request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

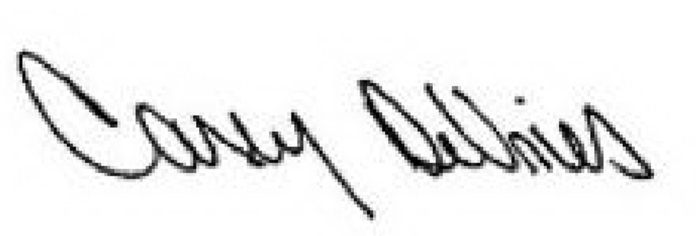
To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms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

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,



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

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31696	A. BUILDING: _____ B. WING _____	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAVAGE SENIOR LIVING	5950 WEST 130TH LANE SAVAGE, MN 55378

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL31696016-0 On November 18, 2024, through November 21, 2024, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 133 resident(s); 48 receiving services under the Assisted Living Facility with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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0 480	Continued From page 1 (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are	0 480		

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0 480	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated November 19, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer	0 480		

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0 480	Continued From page 3 to the FBEIR for any compliance dates.	0 480		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an effective infection control program that complied with accepted health care, medical, and nursing standards for infection control related to gloving and hand hygiene for one of two unlicensed personnel ((ULP)-F). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	0 510		

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0 510	Continued From page 4 ULP-F was hired on March 21, 2022, to provide assisted living services to residents. On November 19, 2024, from 6:58 a.m. to 8:52 a.m., during continuous observation, the surveyor observed ULP-F provide assisted living services to multiple residents residing within the memory care unit. On November 29, 2024, at 7:00 a.m., the surveyor observed ULP-F enter the room of R6, complete hand hygiene and put on clean gloves. ULP-F then began preparing medications for administration. The surveyor observed ULP-F administer prepared medications to R6 at 7:10 a.m., and without completing hand hygiene or putting on clean gloves, ULP-F assisted R6 into the bathroom. Without completing hand hygiene or putting on clean gloves, ULP-F administered eye drops to R6. At 7:13 a.m., ULP-F assisted R6 to put on clean clothing in the bathroom. At 7:17 a.m., ULP-F removed their dirty gloves and without completing hand hygiene, put on clean gloves. ULP-F provided R6 with perineal cares and applied cream to R6's perineal area. At 7:19 a.m., ULP-F removed their soiled gloves, and without completing hand hygiene assisted R6 with oral cares at the bathroom sink. At 7:26 a.m., the surveyor observed ULP-F put on a clean pair of gloves without completing hand hygiene and was then observed cleaning up the living are of R6's room. At 7:27 a.m., ULP-F removed gloves, completed hand hygiene, and then exited the room. On November 19, 2024, at 7:49 a.m., the surveyor observed ULP-F complete hand hygiene at the kitchenette sink, and then enter the room of R9. ULP-F put on clean gloves upon entering the	0 510		

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0 510	Continued From page 5 room and began preparing medications for administration. At approximately 8:05 a.m., ULP-F administered medications to R9, and then assisted R9 to the bathroom. At 8:07 a.m., ULP-F removed their gloves and put on new gloves without completing hand hygiene while conversing with R9 and at 8:08 a.m., ULP-F again removed their gloves without having completed any task and completed hand hygiene at the sink. On November 19, 2024, at 8:09 a.m., the surveyor observed ULP-F enter the room of R10, and put on clean gloves without completing hand hygiene. ULP-F assisted R10 to the bathroom to change their catheter appliance. At 8:17 a.m., ULP-F changed gloves without completing hand hygiene, and then began preparing medications for administration. On November 19, 2024, at 8:28 a.m., ULP-F stated they were trained to complete hand hygiene between all glove changes. On November 21, 2024, at 12:06 p.m., clinical nurse supervisor (CNS)-C stated the expectation of the licensee was for staff to complete hand hygiene before, after, and in between all glove changes. The licensee's Standard Infection Control Practices policy, dated July 21, 2021, indicated clean gloves are to be worn when touching blood, bodily fluids, feces, or contaminated items. Gloves are to be changed between tasks and procedures on the same client. In addition, the policy indicated staff will wash hands before purring on gloves, immediately after glove removal, and as necessary between tasks and procedures on the same client to prevent cross	0 510		

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0 510	Continued From page 6 contamination of different body sites. The Centers for Disease Control's (CDC), "CDC's Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings" dated April 12, 2024, under section 5a.2 read: 2.) Use an alcohol-based hand rub or wash with soap and water for the following clinical indications: a.) Immediately before touching a patient; b.) Before performing an aseptic task (e.g., placing an indwelling device) or handling invasive medical devices; c.) Before moving from work on a soiled body site to a clean body site on the same patient; d.) After touching a patient or the patient's immediate environment; e.) After contact with blood, body fluids or contaminated surfaces; and f.) Immediately after glove removal. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 650 SS=E	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency	0 650		

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0 650	Continued From page 7 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 interview and record review, the licensee failed to ensure the employee record contained the required content for two of three employees (unlicensed personnel (ULP)-E, ULP-F). 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: ULP-E ULP-E was hired on July 10, 2018, by the licensee's former management and hired by the current management on August 28, 2024, to provide direct care services to residents.	0 650		

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0 650	Continued From page 8 ULP-E's personnel file lacked the following required content: - training: - documentation requirements for all services provided; - reports of changes in the residents condition to the supervisor designated by the assisted living provider; - care and use of hearing aids; - dressing and assisting with toileting; - standby assistance techniques and how to perform them; - observation reporting, and documenting resident status; - reading and recording temperature, pulse and respirations of the resident; - recognizing physical, emotional, cognitive, and developmental needs of the resident; - safe transfer techniques and ambulation; - range of motion and positioning; and - administering medications on all route procedures. - competency evaluations: - hair care and bathing; - care of teeth, gums, and oral prosthetic devices; - care and use of hearing aids; - dressing and assisting with toileting; - standby assistance techniques and how to perform them; - reading and recording temperature, pulse and respirations of the resident; - safe transfer techniques and ambulation; - range of motion and positioning; and - administering medications on all route procedures. ULP-F ULP-F was hired on February 21, 2022, by the licensee's former management and hired by the	0 650		

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0 650	Continued From page 9 current management on August 28, 2024, to provide direct care services to residents. ULP-F's personnel file lacked the following required content: - training: - documentation requirements for all services provided; - recognizing physical, emotional, cognitive, and developmental needs of the client; and - medication administration on all route procedures. - competencies: - hair care and bathing; - care of teeth, gums, and oral prosthetic devices; - care and use of hearing aids; - dressing and assisting with toileting; - standby assistance techniques and how to perform them; - reading and recording temperature, pulse and respirations of the resident; - safe transfer techniques and ambulation; - range of motion and positioning; and - administering medications on all route procedures. On November 20, 2024, at 10:59 a.m., ULP-E stated they were trained and received competency evaluations on the content listed above at an in-person corporate training completed upon hire in Bloomington. ULP-E stated they had to complete the trainings and competency evaluations prior to shadowing someone at the facility. On November 20, 2024, at 11:06 a.m., ULP-F stated they were trained and received competency evaluations on the content listed above upon hire, at a corporate training that was	0 650		

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0 650	Continued From page 10 five days long located in Richfield. On November 20, 2024, at 11:17 a.m., clinical nurse supervisor (CNS)-C stated the information in the employee file was all the information they had on ULP-E and ULP-F related to training and competencies. CNS-C stated what was in the employee file was what was provided from the old management and was what was purchased during the change of ownership. CNS-C stated they noticed not all of the trainings and competencies were provided to the new management for the ULP who transitioned with the company and because of this, the licensee was going to conduct a full day training with all ULPs that contained the trainings and competencies listed above. CNS-C stated they have completed the training class which included competency evaluations with approximately ten ULP and had the remaining ULP scheduled for training this week. The surveyor inquired how many staff were hired before the change of ownership. CNS-C stated 90 percent of ULP were hired prior to the change of ownership and would need to take the course. The licensee's document titled Team Member Personnel File - MN dated September 7, 2022, indicated an employee's personnel record would include onboarding checklist, record of initial orientation, record of competency check list, Relias (a training software) training, and annual training. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 680	Continued From page 11	0 680		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a written emergency preparedness plan (EPP) with all the required content as defined in Appendix Z. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	0 680		

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	31696	A. BUILDING: _____ B. WING _____	11/21/2024

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0 680	Continued From page 12 resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's undated emergency disaster preparedness plan binder lacked evidence of the following required content: - documentation of EPP date and dates EPP was reviewed and revised; - a missing resident plan and quarterly review of the missing resident plan; - subsistence needs for staff and residents specific to the needs of the facility; - arrangements with other facilities for evacuation; - roles under a waiver declared by secretary; and - emergency preparation testing requirements. On November 20, 2024, at 1:02 p.m., licensed assisted living director (LALD)-A stated the EPP should have been created on August 28, 2024, when the licensee transitioned ownership however, LALD-A stated they were unable to locate a date for when the EPP was created. LALD-A stated the previous ownership reviewed the missing resident plan one time per year and completed training and drill at that time. LALD-A stated they did not have any documentation for the times the missing resident plan was reviewed. LALD-A stated the EPP did not have an appendix that addressed the substance needs for the licensee. LALD-A stated they had a place to evacuate to in case of an emergency however, they did not have a written agreement documented. LALD-A stated the EPP did not address roles under a waiver declared by	0 680		

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0 680	Continued From page 13 secretary. LALD-A stated the licensee did not conduct any emergency preparedness plan drills since the new ownership which occurred August 28, 2024. Regional director (RD)-D stated the licensee's EPP lacked roles under a waiver declared by secretary, and they have escalated the problem to their supervisor. RD-D stated the licensee's plan going forward would be to review the missing resident plan quarterly at the quality management meetings. RD-D stated they had not reviewed the missing resident policy but plan to review it within their first quarter. RD-D stated they were currently in the process of training staff on the new EPP and had completed trainings on seven employees. The licensee's Disaster Planning and Emergency Preparedness Plan policy dated April 2022, indicated the licensee would have a written disaster plan that contained a plan for evacuation, addresses elements of sheltering in place, identified temporary relocation sites, and detailed staff assignments in the event of a disaster or emergency. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 900 SS=F	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing;	0 900		

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0 900	Continued From page 14 (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to develop and execute a written assisted living contract with the required content for individuals residing in the assisted living facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large	0 900		

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0 900	Continued From page 15 portion or all the residents). The findings include: The licensee was licensed for 145 residents and had a census of 133 residents. On November 19, 2024, at 10:49 a.m., clinical nurse supervisor (CNS)-C stated there may be contract addendums distributed to residents to indicate the change of ownership. On November 19, 2024, at 11:44 a.m., regional director (RD)-D stated there were no new contracts signed at the time of the change of owner ship (CHOW). RD-D stated there were some addendums signed, but the licensee would need to ensure that new contracts were signed. RD-D stated they would need to issue new contracts to all residents as the previous contract listed a different managing agent and authorized agent/owner. On November 20, 2024, at 1:02 p.m., licensed assisted living director (LALD)-A stated the licensee underwent a CHOW on August 28, 2024. On November 21, 2024, 12:18 p.m. LALD-A stated addendums were issued to notify residents that old leases were still in place. LALD-A stated that in total, approximately 15 new contracts had been issued since the licensee's CHOW. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 900		

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01620	Continued From page 16	01620		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to complete a change of condition reassessment when a resident presented with new or changed symptoms for two of two residents (R4, R9) and failed to ensure the registered nurse (RN) completed a 14-day reassessment for one of five residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or	01620		

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01620	Continued From page 17 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: CHANGE OF CONDITION R4 R4 admitted to the licensee on August 2, 2023, and began receiving assisted living services. R4's diagnoses included dementia unspecified severity and cerebrovascular disease. R4's Service Plan Agreement signed July 17, 2024, indicated R4 received assistance with housekeeping, laundry, oral medication administration, and safety checks. The service plan also indicated R4 was independent with activities, bathing, dining, dressing, hearing aids, grooming, nail care, oral care, ambulation, bed mobility, transfers, and toileting. R4's progress notes dated October 11, 2024, at 3:41 p.m., and 7:32 p.m., indicated R4 was taken to urgent care for a puncture wound to the right index finger that would not stop bleeding. R4 received a tetanus, diphtheria, pertussis (TDAP) vaccine and was prescribed a new wound care order. R4's progress notes on October 18, 2024, at 12:18 p.m., and 3:17 p.m., indicated R4 was taken to urgent care due to growth on the wound bed. R4 received the new orders of holding aspirin, topical antibiotics, and a new wound care	01620		

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01620	Continued From page 18 order. R4's progress note dated October 31, 2021, indicated R4's blood pressure readings were high in the morning hours and there was a medication change to metoprolol (a blood pressure medication). R4's progress note dated November 6, 2024, at 10:41 a.m., indicated R4 pushed their pendant and reported feeling dizzy. R4's blood pressure (BP) was 189/93 millimeters of mercury (mm Hg). The note indicated R4 was assessed by a RN and the RN noted R4 did not sleep well, felt dizzy, had +1 non pitting edema to their feet, and showed signs of orthostatic hypertension (a drop of 20 mm hg in the systolic blood pressure or a 10 mm Hg in the diastolic blood pressure within 2 to 5 minutes of standing). The RN contacted the provider with no changes made to R4 plan of care. R4's progress note dated November 6, 2024, at 4:48 p.m., indicated R4 fell and was found sitting on the floor during a safety check. The note indicated R4 was assessed by a RN and the RN noted R4 struck their head during the fall, had increased confusion, reported dizziness, had an elevated blood pressure, showed signs of orthostatic hypotension, edema increased to +3 on the feet and the lower extremities, increased weakness and shaking, and R4 needed assistance for ambulation. The RN called the prescriber who recommended R4 be sent to the emergency room for evaluation. R4 was taken to the emergency room by family. R4's progress note dated November 7, 2024, at 1:29 p.m., indicated R4 returned from the emergency room with a new order to start	01620		

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01620	Continued From page 19 furosemide (a diuretic) 20 milligrams (mg) for seven days. In addition, R4 was ambulating without difficulty and was alert to their baseline for cognition. R4's progress note dated November 8, 2024, at 4:05 a.m., indicated on November 7, 2024, at 10:15 p.m., R4 fell between the bedroom and bathroom when they tripped and R4's family and provider were notified. R4's progress note dated November 8, 2024, at 10:27 a.m., indicated on November 8, 2024, at 8:45 a.m., R4 fell in their living room. The note indicated R4 was assessed by a RN and the RN noted R4 was at their baseline for cognition, felt dizzy, showed signs of orthostatic hypotension, and edema was present to the feet. The RN contacted the family and the provider who recommended increased fluids and stand slowly when initiating walking to prevent dizziness. R4's progress note dated November 8, 2024, at 11:58 a.m., indicated at 11:00 a.m., R4 fell in their bathroom after their right leg "gave out". The note indicated R4 was assessed by a RN and the RN noted R4 had a new wound to the left foot and R4 was dizzy. The RN offered a wheelchair to R4 however, R4 declined. The RN notified the provider and R4's family. R4's family indicated they would bring a cane to the facility for R4. R4's progress note dated November 8, 2024, at 2:40 p.m., indicated R4 received new orders from the provider. The new orders included a decrease to gabapentin, change of time to Aricept, physical and occupational therapy evaluation, lipid panel blood test, comprehensive metabolic panel (CMP) blood test, and for family to provide a walker instead of a cane.	01620		

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01620	Continued From page 20 R4's progress note dated November 8, 2024, at 2:46 p.m., indicated at 1:00 p.m., R4 fell in their living room. The note indicated R4 was assessed by a RN and the RN noted R4 had weakness to both extremities, bruising on arms, elevated blood pressure, and was not stable with ambulation. The RN recommended an emergency room visit however; family wanted to discuss if they wanted R4 to go to the hospital because R4 had recent emergency room visits with no findings of what was causing the issues. In addition, the family contacted the provider. R4's progress note dated November 8, 2024, at 3:48 p.m., indicated R4 was sent to the emergency room via non-emergency transport. R4's progress note dated November 12, 2024, indicated was admitted to the hospital and R4 was still in the hospital. R4's record included an ongoing 90-day assessment completed on August 19, 2024. The assessment indicated the following: - R4 had no skin concerns needing treatment or monitoring; - R4 did not have confusion, delirium, or disorientation; - R4 had no falls within the last quarter; - R4 was able to ambulate independently; - R4 did not use any ambulation devices; and - did not indicate if R4 had any edema. R4's record lacked a change of condition assessment that should have been completed after R4 experienced changes in medication, skin (edema), cognition, and mobility. R9	01620		

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01620	Continued From page 21 R9 was admitted to the license on June 17, 2015, and began receiving assisted living services on August 1, 2021. R9's diagnosis included depression unspecified, essential hypertension, pure hypercholesterolemia, and hypothyroidism. R9's Service plan Agreement dated June 24, 2024, indicated R9 received assistance with activities, bathing, dining, dressing, hearing aids, vision aid, grooming, nail care, oral care, toenail care, continuous positive airway pressure/bilevel positive airway pressure (CPAP/BIPAP), ambulation, bed mobility, transfers, emergency evacuation assistance, toileting, housekeeping, laundry, and safety check. R9's unsigned Service Plan dated November 19, 2024, indicated R9 received assistance with nail care, care coordination, housekeeping, laundry, medication administration, and safety checks due to being a falls risk. R9's progress note dated November 11, 2024, at 9:54 a.m., indicated R9 fell while getting into the shower and after the fall their left hand was unable to move and was swollen. R9's son took R9 to the emergency room for further evaluation of the left hand. R9's progress note dated November 11, 2024, at 2:20 p.m., indicated R9 returned from the emergency room with a left arm immobilizer cast and a diagnosis of closed fracture of distal end of left radius. R9's record included ongoing 90-day resident assessment dated October 7, 2024. The assessment was completed prior to R9's fall and	01620		

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01620	Continued From page 22 diagnosis closed fracture of distal end of left radius. R9's record lacked change of condition assessment following R9's change of condition which occurred on November 11, 2024. On November 21, 2024, at 10:01 a.m., clinical nurse supervisor (CNS)-C stated a change of condition assessment would be completed anytime there was a resumption of care or change in the residents' condition including swallowing, mobility, cognition, a baseline change, and if a service needed to be added to the service plan. CNS-C stated if the nurse was onsite, the change of condition assessment would occur immediately and if there was not one onsite, it would occur the following day when a nurse arrived. CNS-C stated R4 was orientated x2 or x3 (a term used to describe a person's awareness of their situation to describe mental status) depending on the day, had no edema, was independent "all together" for care, and the licensee only provided medication management and safety checks prior to the falls. The surveyor inquired if it was correct to say furosemide was a new medication, edema was a new symptom R4 was experiencing, needing assistance with mobility was new for R4, and confusion was not R4 normal baseline. CNS-C stated yes those were changed for R4 however, R4's dizziness was not new, and the providers were adjusting medications for the past five or six months to relieve the symptom. CNS-C stated the new edema for R4 "would be pretty standard for evaluating. Different nurses different thinking." The surveyor inquired what the clinical decision was for not completing a change of condition on R4. CNS-C stated, "probably should have had it done." CNS-C stated they were not sure if the change of condition assessment was not completed because no services were added to	01620		

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01620	Continued From page 23 the service plan. CNS-C stated, "I don't have a good answer for that one." CNS-C stated if there was a change of condition to the resident it should trigger a change of condition assessment. CNS-C stated R4 was still in the hospital however, they were coming due for a 90-day assessment to be completed and they would conduct an assessment upon R4's return. On November 21, 2024, at 12:08 p.m., CNS-C stated that a change of condition assessment should have been completed on R9 to ensure adequate services were being provided. 14- DAY ASSESSMENT R2 R2 was admitted to the licensee on September 6, 2024, to receive assisted living services. R2's diagnosis included dementia, type 2 diabetes mellitus with other specified complication, other abnormal findings of blood chemistry, and vitamin D deficiency. R2's Service Plan Agreement dated September 20, 2024, indicated R2 received assistance with assessments, housekeeping, laundry, medication administration and set up, ambulation, transfers, escorts, safety check due to fall risk, and toileting assistance. R2's record contained an admission assessment dated September 10, 2024, which indicated four days had lapsed since the documented admission date. R2's 14-day assessment occurred on September 30, 2024, which indicated that twenty days had lapsed since R2's admission assessment. On November 18, 2024, at approximately 10:30	01620		

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01620	Continued From page 24 a.m., clinical nurse supervisor (CNS)-C stated the registered nurse would complete assessments upon preadmission, admission, fourteen days after admission, 30 days after admission, and then every 90 days or with a change of condition. On November 21, 2024, at approximately 12:26 p.m., CNS-C stated the assessment should have been completed by day 14, but was unable to give a reason as to why it was not completed on time. The licensee's Comprehensive Resident Assessment, Monitoring, & Reassessment policy dated July 19, 2021, indicated the following: "The RN documents the assessment in the resident record and within 14 days of creating or revising the resident service plan, finalizes a current written plan based on assessment and resident preference.", and "Abnormal signs and symptoms, or changes in condition, are reported to a community RN who will update resident's assessments and discuss changes with resident and/or resident's authorized representative, physician or any other health care provider as needed. The service plan will be updated as needed. Any changes in the resident's service agreement require a new service agreement." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31696	A. BUILDING: _____ B. WING _____	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAVAGE SENIOR LIVING	5950 WEST 130TH LANE SAVAGE, MN 55378

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01640	Continued From page 25 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 ensure the service plan included a signature or other authentication by the resident or resident's designated representative to document agreement on the services to be provided for one of four residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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).	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31696	A. BUILDING: _____ B. WING _____	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01640	Continued From page 26 The findings include: R3 was admitted to the license on July 12, 2024, to receive assisted living services. R3's diagnosis included mild cognitive impairment, restless legs syndrome, obstructive sleep apnea (adult) (pediatric), pure hypercholesterolemia, primary insomnia, trigeminal neuralgia, personal history of other venous thrombosis and embolism, BPH (benign prostatic hyperplasia), orthostatic hypotension, benign neoplasm of duodenum and diverticulosis of large intestine without perforation or abscess without bleeding. R3's signed Service Plan Agreement dated September 26, 2024, indicated R3 received assistance with dining reminders, assessments, housekeeping, medication administration, reassurance visit, and safety/security check. R3's prescriber orders signed October 31, 2024, included indwelling foley catheter and catheter care. R3's Service Plan Agreement with a print date of November 18, 2024, indicated the R3 received assistance with dining reminders, assessments, housekeeping, laundry, medication administration, reassurance visit, and safety/security check, catheter care, catheter: empty bag. R3's Service Delivery Record indicated that R3 received assistance with the following services which were not included on R3's signed Service Plan Agreement dated September 26, 2024: - laundry;	01640		

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	31696	A. BUILDING: _____ B. WING _____	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01640	Continued From page 27 - catheter care; and - catheter: empty bag. R3's record lacked a current service plan with signature or authentication by the resident or resident's representative with all current services provide by licensee after addition of services on or after November 1, 2024. On November 20, 2024, at 12:49 p.m., clinical nurse supervisor (CNS)-C stated R3's service plan did not include the catheter care service, and she had just linked the services to the service plan, and that they would work on getting this new service plan signed. On November 21, 2024, at 12:49 p.m., clinical nurse supervisor (CNS)-C stated service plans were revised if there was a new service. CNS-C stated the nurses also contact the family to update them when new services were added to their plan of care. On Novermeber 21, at 2024, at 1:09 p.m., regional director (R)-D stated they were supposed to have signed authorizations for all services. The licensee's Resident Service Plans policy dated July 13, 2021, indicated a service plan was reviewed and modified as necessary based on a change in the resident's health or other dimensions of wellbeing, or at the time of mandated periodic resident assessment every 90 days. In addition, upon finalization of the service plan, the registered nurse (RN) reviewed the plan with the resident and/or resident responsible party and if the resident and/or resident responsible party agrees with the service plan, the RN and resident or resident designee signs, or otherwise	01640		

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	31696	A. BUILDING: _____ B. WING _____	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAVAGE SENIOR LIVING	5950 WEST 130TH LANE SAVAGE, MN 55378

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01640	Continued From page 28 authenticates, the plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications was administered per physician orders for one of six residents (10). 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	01760		

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	31696	A. BUILDING: _____ B. WING _____	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAVAGE SENIOR LIVING	5950 WEST 130TH LANE SAVAGE, MN 55378

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01760	Continued From page 29 only occasionally). The findings include: R10's diagnoses included chronic diastolic (congestive) heart failure, hyperosmolality and hypernatremia, hypokalemia, acute lymphoblastic leukemia not having achieved remission, retention of urine, unspecified, essential (primary) hypertension, unspecified dementia without behavioral disturbance, peripheral vascular disease, unspecified, unilateral primary osteoarthritis of the right hip, gastroesophageal reflux disease without esophagitis, essential tremor, recurrent falls, and impaired fasting glucose. R10's Service Plan Agreement signed April 24, 2023, indicated R10 received assistance with bathing, application of hearing aids, weight monitoring, medication administration, assistance with ambulation, escort services, assistance with transfers, and assistance with catheter maintenance. R10's provider orders dated October 15, 2023, indicated R10 received diclofenac (Voltaren) 1% topical gel, apply 2g topically four times daily as needed. Apply to hip, knee, or feet. On November 19, 2024, at 8:24 a.m., the surveyor observed unlicensed personnel (ULP)-F take R10's diflonac cream out of the locked medication cabinet. ULP-F dispensed an unmeasured amount into a gloved hand, and then applied the unmeasured amount of cream onto the feet of R10. The surveyor asked ULP-F how they had measured the amount of cream to apply, to which ULP-F said they applied a thin layer to the feet. The surveyor asked ULP-F if they had	01760		

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01760	Continued From page 30 been trained to measure the amount of diclofenac cream to apply using the provided plastic dosing card. ULP-F stated they were trained to use this measurement card but had not done so in error. On November 11, 2024, at 12:00 p.m., clinical nurse supervisor (CNS)-C stated that staff were trained to use medication measurement cards when applying medicated creams. The licensee's Administration of Medication policy dated September 13, 2021, indicated staff who are preparing and giving medications will Follow the "6 rights" of medication administration to verify proper administration for prescription drugs: i. Right person ii. Right medication iii. Right time iv. Right route (e.g., by mouth, eye drops, topical) v. Right dose (e.g., number of tablets, milligrams, drops) vi. Right documentation of who administered the medication and when/how the medication was taken. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		

Minnesota Department of Health
Environmental Health, FPLS
P.O. Box 64975
St. Paul, MN 55164-0975
6512014500

Type: Full
Date: *11/19/24*
Time: 12:30:00
Report: 1047241324

Food and Beverage Establishment Inspection Report

Location:
Savage Senior Living
5950 West 130th Lane
Savage, MN55378
Scott County, 70

Establishment Info:
ID #: 0038552
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 9528088725
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.

THE HOLDING TEMPERATURE OF THE GLASS DOOR DISPLAY COOLER WAS HOVERING AROUND 41-43F. DISCUSSED REPLACING THE GASKET TO ALLOW COOLER TO SEAL PROPERLY. TEMPERATURE OF COOLER WAS ADJUSTED AT TIME OF INSPECTION.

Comply By: 11/19/24

Surface and Equipment Sanitizers

Hot Water: = at 167 Degrees Fahrenheit
Location: Dishmachine
Violation Issued: No

Quaternary Ammonia: = 200 ppm at Degrees Fahrenheit
Location: Sanitizer bucket
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Hot Holding
Temperature: 174 Degrees Fahrenheit - Location: Soup warmer- soup
Violation Issued: No

Process/Item: Cold Holding
Temperature: 37 Degrees Fahrenheit - Location: Walk in- raw beef
Violation Issued: No

Food and Beverage Establishment Inspection Report

Process/Item: Cold Holding
Temperature: 39 Degrees Fahrenheit - Location: True fridge- salad
Violation Issued: No

Process/Item: Cold Holding
Temperature: 38 Degrees Fahrenheit - Location: Milk dispenser-milk
Violation Issued: No

Process/Item: Cold Holding
Temperature: 36 Degrees Fahrenheit - Location: Prep cooler- egg salad
Violation Issued: No

Process/Item: Cold Holding
Temperature: 38 Degrees Fahrenheit - Location: True fridge on line-ground beef
Violation Issued: No

Process/Item: Cold Holding
Temperature: 42 Degrees Fahrenheit - Location: Display cooler- milk
Violation Issued: Yes

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

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

The establishment has a commercial kitchen.

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

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 1047241324 of 11/19/24.

Certified Food Protection Manager: Matthew L. Gaughan

Certification Number: FM120395 Expires: 11/13/26

Inspection report reviewed with person in charge and emailed.

Signed: _____
Matthew Gaughan
Culinary Director

Signed: _____
Holly Sievers
Public Health Sanitarian 2
Metro Office
6512015946
Holly.Sievers@state.mn.us