DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

August 26, 2025

Licensee
Okalee of Medina
4350 Chippewa Court
Medina, MN 55340

RE: Project Number(s) SL35700016

Dear Licensee:

On July 2, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on December 6, 2024. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

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

HHH

Electronically Delivered

March 13, 2025

Licensee
Okalee of Medina
4350 Chippewa Court
Medina, MN 55340

RE: Project Number(s) SL35700016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on December 6, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

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

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

St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required - $3,000.00
St - 0 - 1750 - 144g.71 Subd. 7 - Delegation Of Medication Administration - $3,000.00
St - 0 - 1950 - 144g.72 Subd. 4 - Administration Of Treatments And Therapy - $3,000.00
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 $12,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

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

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

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

INFORMAL CONFERENCE
In accordance with Minn. Stat. § 144A.475, Subd. 8 OR Minn. Stat. § 144G.20, Subd. 20, the Commissioner of Health is authorized to hold a conference to exchange information, clarify issues, or resolve issues. The Department of Health staff would like to schedule a conference call with Okalee of Medina. Please contact Kelly Thorson at 320-223-7336 on or before **Tuesday, March 18, 2025**, to schedule the conference call.

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,

Kelly Thorson

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35700	A. BUILDING: _____ B. WING _____	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OKALEE OF MEDINA	4350 CHIPPEWA COURT MEDINA, MN 55340

(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: SL35700016-0 On December 2, 2024, through December 6, 2024, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 84 resident(s); 42 receiving services under the Assisted Living Facility with Dementia Care license. During the course of the survey, the licensee failed to take action to mitigate the imminent risk identified in the immediate orders.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 250 SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a	0 250		

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0 250	Continued From page 1 provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or staff of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or staff; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4, or interferes with or impedes access by the Office of Ombudsman for Mental Health and Developmental Disabilities according to section 245.94, subdivision 1; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under	0 250		

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0 250	Continued From page 2 section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to show they met the requirements of licensure, by attesting the managerial officials who oversaw the day-to-day operations understood applicable statutes and rules; nor developed and/or implemented current policies and procedures as required with records reviewed. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On December 3, 2024, at approximately 10:56	0 250		

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

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

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0 250	Continued From page 5 attachments and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct, and complete. I will notify MDH, in writing, of any changes to this information as required. - I attest to have all required policies and procedures of Minn. Stat. chapter 144G and Minn. Rules chapter 4659 in place upon licensure and to keep them current as applicable. Page 6 was electronically signed by executive director (ED)-F on August 23, 2024. The licensee had an assisted living license issued on September 1 2024, with an expiration date of August 31, 2025. The licensee failed to ensure the following policies and procedures were developed and/or implemented: - conducting and handling background studies on employees; - orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; - conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate;	0 250		

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0 250	Continued From page 6 - implementation of the assisted living bill of rights; - medication and treatment management; and - delegation of tasks by registered nurses or licensed health professionals. On December 5, 2024, at 1:25 p.m., LALD-C confirmed the licensee provided Assisted living services but failed to develop and implement corresponding policies and procedures, as required. As a result of this survey, the following orders were issued 0250, 0480, 0510, 0630, 0650, 0680, 0700, 0730, 0800, 0810, 0950, 1060, 1290, 1440, 1470, 1620, 1750, 1880, 1910, 1940, 1960, 2040 and 23100 indicating the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.08 to 144G.95. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 250		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a	0 480		

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0 480	Continued From page 7 certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant 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	0 480		

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0 480	Continued From page 8 (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated December 3, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 510 SS=D	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.	0 510		

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0 510	Continued From page 9 (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 maintain an effective infection control program to comply with acceptable health care, medical, and nursing standards for infection control by one of three 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) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-B was hired May 8, 2020, to provide direct cares and services to residents. On December 3, 2024, at 8:06 a.m., ULP-B helped R4 to the bathroom, ULP-B donned gloves and helped R4 with AM cares, ULP-B applied lotion to R4's bilateral lower extremities, applied compression stocking (TEDS), and then provided peri care. ULP-B removed gloves and without completing hand hygiene donned new	0 510		

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0 510	Continued From page 10 gloves and completed dressing R4 and then ULP-B got R4's toothbrush and toothpaste set out for use. ULP-B doffed gloves without completing hand hygiene placed toothpaste on toothbrush and gave it to R4, without completing hand hygiene ULP-B donned gloves and cleaned up bathroom and than took R4's soiled linens and incontinence products to the to the laundry room and started laundry. ULP-B then doffed gloves and without preforming hand hygiene ULP-B donned clean gloves to start a med pass for another resident. The surveyor stoped ULP-B and asked when should hand hygiene be preformed? ULP-B stated, "hand hygiene should be preformed before we start the next task." ULP-B then doffed gloves and washed hands and stated, "I guess we are anxious that state is in the building." On December 3, 2024, at 8:28 a.m., ULP-B washed hands, and donned gloves and assisted R5 with eye drops. ULP-B doffed gloves and without preforming hand hygiene donned new gloves and cleaned R5's room and made the bed and then put in R5's hearing aides. ULP-B doffed gloves and washed hands. On December 3, 2024, at 10:32 a.m., interim clinical nurse supervisor (ICNS)-D stated, "Hand washing and gloving, they should be changing in between tasks and washing before they start with medication and washing when done and changing and washing in between peri care or those things." The licensee's Infection prevention and control policy dated December 23, 2019, indicated, "Handwashing and hand sanitizing using alcohol based hand sanitizer is the cornerstone of this program. The policy lacked to cover when hand	0 510		

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	35700	A. BUILDING: _____ B. WING _____	12/06/2024

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0 510	Continued From page 11 hygiene and gloving would need to be completed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 630 SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for three of three independent residents (R1, R2 and 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 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	0 630		

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0 630	Continued From page 12 portion or all of the residents). The findings include: R1 R1 was an independent resident and moved into the licensee's facility on August 13, 2024. R2 R2 was an independent resident and moved into the licensee's facility on March 31, 2023. R3 R3 was an independent resident and moved into the licensee's facility on March 31, 2023. R1, R2, and R3's record lacked an individualized review or assessment of the resident's susceptibility to abuse by other individuals, and the specific measures to be taken to minimize the risk of abuse to the resident or other vulnerable adults and risk of self-abuse. On December 3, 2024, at 10:21 a.m. interim clinical nurse supervisor (ICNS)-D stated, "I am going to guess that they didn't even know that that was something that was a part of the process for IAPP. I don't think they even realized that they had to do that for independent residents." The licensee's Abuse Prohibition policy dated February 21, 2019, indicated "All tenants of the facility are considered vulnerable adults. Therefore, Registered Nurse evaluates the vulnerability of each vulnerable adult and develops interventions as part of the individual abuse prevention plan." No further information provided.	0 630		

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0 630	Continued From page 13 TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
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 have a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all residents, staff and visitors.	0 680		

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0 680	Continued From page 14 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's emergency disaster preparedness plan lacked evidence of the following required content: - Review annually the EP risk assessment that considered hazards like care related emergencies, equipment/utility failures, interruptions in communications/cyber-attacks, loss of all or portion of a facility, interruption to normal supply of essential resources and medical supplies; - Develop and implement EP policies/procedures (P/P) based on the EP risk assessment; - Must document the risk assessment - Must take an all-hazards approach, including EIDs, as applicable - Categorize the various probable risks/hazards by likelihood of occurrence - Must develop strategies for addressing facility & community-based risks (i.e.: evacuation plans, staffing surges/shortages, back-up plans) - Must identify at risk population needs like maintaining independence, communication, transportation, supervision and medical care. - Must identify which staff would assume specific roles in another's absence through succession planning and delegation of authority. - Develop P/P of arrangements with other	0 680		

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0 680	Continued From page 15 facilities/providers to receive residents in the event of limitations/cessation of operations to maintain the continuity of services to residents; - Conduct exercises to test the EP at least twice per year, including unannounced staff drills using the EP and must include the following: - Participate in an annual full-scale exercise that is community based OR conduct an annual, individual, facility-based functional exercise OR if the facility experiences an actual emergency requiring activation of plan, facility is exempt from engaging in its next required full-scale exercise; - Conduct an additional annual exercise that may include: a second full-scale exercise that is community-based or an individual, facility based functional exercise OR mock disaster drill OR table-top exercise; and - Analyze the facility's response to and maintain documentation of all drills, tabletop exercises and emergency events & revise plan as needed. On December 5, 2024, at 4:01 p.m. licensed assisted living director (LALD)-C stated, "I wasn't in the role, so it's hard to know what was established prior to me coming in and the time I have been here I have been learning my role." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 700 SS=F	144G.43 Subdivision 1 Resident record (b) Resident records, whether written or electronic, must be protected against loss, tampering, or unauthorized disclosure in compliance with chapter 13 and other applicable relevant federal and state laws. The facility shall	0 700		

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0 700	Continued From page 16 establish and implement written procedures to control use, storage, and security of resident records and establish criteria for release of resident information. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure residents' personal health and medical information was kept private. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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: On December 3, 2024, at 8:40 a.m., surveyor observed ULP-B pull up R13's electronic medication administration record (EMAR) on ULP-B's portable handheld electric device, then set the device down on the medication cart in the common area, with the screen facing up and walk away to obtain a glass of water from another area in the facility. There were three employees, and seven residents in the common area at the time. On December 3, 2024, at 8:45 a.m., surveyor observed ULP-B pass medications for R4 and ULP-B ripped off the tops of the medication punch packs with R4's medical information on it and placed it on the med cart with other punch pack tops for other residents.	0 700		

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0 700	Continued From page 17 On December 3, 2024, at 10:28 a.m., ULP-B stated, "We always pull the tops off of the empty [punch packs] and keep them up there (on top of medication cart) and we take them upstairs at the end of the shift." On December 3, 2024, at 8:46 a.m., interim clinical nurse supervisor (ICNS)-D stated, "I know they each have their own login on Rtasks and other than that I have no idea what they have been taught or told, HIPPA is kind of a big deal, but from what I know they only use their hand held and I have never seen anyone leave those around. I didn't know they were keeping the tops of the med cards on the cart." The licensee's Charting and Documentation policy, dated March 13, 2023, indicated, "Information documented in the resident's clinical record is confidential and may only be released in accordance with state law, the Health Insurance Portability and Accountability Act (HIPAA) and facility policy. Refer all requests for information to the Director of Nursing Services, Nurse Supervisor/Charge Nurse and to Regional Clinical/Ops team." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 700		
0 730 SS=D	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	0 730		

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0 730	Continued From page 18 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 any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and	0 730		

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0 730	Continued From page 19 (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 interview and record review, the licensee failed to ensure the resident record included a discharge summary with the required content for one of one discharged resident (R8). 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: R8 was admitted to the licensee on October 18, 2021, and discharged to another facility on October 31, 2024. R8's record lacked a discharge summary that complied with part 4659.0120, subpart 9 to include: - treatments and therapies; - pertinent lab, radiology, and consultation results; and - a final summary of the resident's status from the latest assessment or review including baseline and current mental, behavioral, and functional status. On December 5, 2024, at 12:24 a.m., interim clinical nurse supervisor (ICNS)-D stated, "As far	0 730		

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0 730	Continued From page 20 as the discharge summary not having everything, I don't know why they were not doing it right, but we will be going forward." The licensee's Content of Resident Records policy dated August 15, 2019, indicated the licensee will maintain appropriate and accurate records for each resident that received assisted living services. No further information was provided. TIME PERIOD FOR CORRECTIONS: Twenty-one (21) days	0 730		
0 800 SS=D	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and 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, 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. This deficient condition had the potential to affect all staff, residents, and visitors.	0 800		

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0 800	Continued From page 21 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 December 03, 2024, at 10:25 a.m., surveyor toured the facility with maintenance (M)-G. The following maintenance issues were observed. It was found that the trash chute door closer on the second floor, was not working properly so that the door had to be closed manually. M-G stated they understood the above-listed deficiencies. TIME PERIOD FOR CORRECTION: twenty-one (21) days.	0 800		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar	0 810		

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0 810	Continued From page 22 emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required training and drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	0 810		

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0 810	Continued From page 23 The findings include: On December 03, 2024, at 11:15 a.m., executive director (ED)-F provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN: ED-F failed to provide the FSEP (fire safety and evacuation plan) for employee procedures and specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. Survey staff reviewed the fire evacuation diagrams and observed that they did not include where the emergency exits were located. Exit plan diagrams must be correctly labeled to reduce confusion and potential obstructions to egress in a fire or similar emergency. Survey staff observed the fire safety and evacuation plan was not located in a central location for all staff accessibility. ED-F stated they understood the areas of their policy that were incomplete and would work on bringing them into compliance. TRAINING: The licensee failed to provide evacuation training to residents at least once per year. Executive director (ED)-F lacked documentation showing any training was offered or training was scheduled for a future date for residents on the fire safety and evacuation plan. The licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. No	0 810		

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0 810	Continued From page 24 training documentation was provided. ED-F stated that they were doing the training, and he understood the requirements for training residents and staff but was unable to provide the documentation for this. DRILLS: The licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month. Record review of licensee's evacuation drill log indicated evacuation drills were conducted on March 30, 2022, June 22, 2022, and November 18, 2022. No other documentation was provided. ED-F stated that they were doing the evacuation drills quarterly and he understood the requirements for employees twice per year, per shift with at least one evacuation drill every other month. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
0 950 SS=C	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your	0 950		

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0 950	Continued From page 25 "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to offer one of one resident (R5) the opportunity to identify a designated representative in writing with the required statutory language. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On December 2, 2024, at 12:01 p.m., clinical	0 950		

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0 950	Continued From page 26 nurse supervisor (CNS)-E provided the surveyor with a blank contract, and indicated the same contract was used for all residents. The contract had a spot to identify the resident's designated representative on the second page of the contract and indicated, "A Designated Representative is someone who may not have legal authority to act on behalf of a resident but who has been identified by a resident as having authority to receive information and notices about the resident specifically related to the resident's health condition. Although having a Designated Representative can be helpful to both Residents and the Facility, Resident is not obligated to identify such a person." The contract lacked the required statutory language for the designated representative. On December 5, 2024, at 4:05 p.m., licensed assisted living director (LALD)-C acknowledged she was unaware the contract lacked the required statutory language, and stated, "Again, I wasn't in the role, so it's hard to know what was or was not done prior to my start, all I can do is correct it as we Identify it." No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 950		
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination.	01060		

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01060	Continued From page 27 (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the	01060		

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01060	Continued From page 28 licensee failed to provide a written notice with the required content for an emergency relocation to the resident, legal representative, or designated representative and failed to provide the notification to the Office of Ombudsman for Long-Term Care (OOLTC) of the emergency relocation greater than four days for one of one resident (R7). 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: R7 was admitted to the licensee and began receiving assisted living services on May 23, 2022. R7's unsigned Service Plan, indicated R7 received services including assistance with medication administration, vital signs, housekeeping, laundry, linens, skin care, and behavior monitoring. R7's Electronic Medication Administration Record dated November 1, 2024, through December 31, 2024, indicated R7 had been in the hospital from November 28, 2024, through December 2, 2024. R7's record lacked evidence a written notice, with the required statutory content, was provided to resident, or resident representative. On December 4, 2024, at 1:52 p.m., "[RN-A] has	01060		

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01060	Continued From page 29 not been doing emergency relocation forms and the licensee wasn't aware they needed to do this." No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
01290 SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a background study was current and eligible on NETStudy 2.0 (web-based system for submitting background study requests to the Department of Human Services (DHS)) prior to staff providing services for two of fifty-two staff, unlicensed personnel (ULP)-K and maintenance (M)-G.	01290		

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01290	Continued From page 30 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 the potential to affect a large portion or all the residents). The findings include: On December 3, 2024, at 1:49p.m., licensed assisted living director (LALD)-C provided the surveyor with the licensee's NETStudy 2.0 roster. ULP-K ULP-K was hired on September 22, 2023, to perform direct care services to the licensee's residents. ULP-K's employee record lacked evidence of a cleared background study as required. M-G M-G was hired on September 23, 2024, to perform maintenance services to the licensee's facility. M-G's employee record lacked evidence of a cleared background study as required. On December 3, 2024, at 2:51 p.m., LALD-C stated, "So after you get the clearance letter, if you erase them from the [Netstudy roster] then they are no longer in there? So, you are just supposed to leave them in the roster? I thought they could be erased after the clearance came back on them. I wasn't aware of all that."	01290		

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01290	Continued From page 31 On December 3, 2024, at 3:07 p.m., surveyor requested a policy on background studies. On December 3, 2024, at 3:58 p.m., LALD-C stated, "Are you looking for a written policy on how we run background studies? I honestly don't know if they have one." No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	01290		
01440 SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer.	01440		

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01440	Continued From page 32 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) completed supervision of an unlicensed personnel (ULP)-B within 30 calendar days of beginning to provide delegated tasks for one of one employees. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-B ULP-B was hired May 8, 2020, to provide direct care services to the licensee's residents. On December 3, 2024, at 8:06 a.m., surveyor observed ULP-B helped R4 with AM cares. ULP-B's record lacked evidence a RN conducted direct supervision of ULP-B within 30 days of performing delegated tasks. On December 5, 2024, at 4:05 p.m., interim clinical nurse supervisor (ICNS)-D stated, " I wasn't in that role at that time, so I really don't know why it wasn't done, but I know I have not had time to do the 30-day supervisions since I have been here so they have not been getting done."	01440		

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01440	Continued From page 33 The licensee's Supervision of unlicensed staff and licensed staff policy, dated August 2021, read, "Supervision of ULP's by an RN will be direct supervision of the staff and include observation of the staff performing a delegated task(s) within 30 calendar days after the staff member begins working and first performs the delegated resident tasks." No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440		
01470 SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health	01470		

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01470	Continued From page 34 Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the staff member will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employee orientation	01470		

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01470	Continued From page 35 included all required content for seven of nine employees (unlicensed personnel (ULP)-B, ULP-J, ULP-L, ULP-M, ULP-N, ULP-O,and ULP-P). 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: ULP-B ULP-B was hired May 8, 2020, to provide direct cares and services to residents. ULP-B's employee records lacked orientation to assisted living regulations to include the following: - Handing of resident complaints, reporting of complaints, where to report; - Consumer advocacy services; - Review of types of Assisted Living services the employee will provide and provider's scope of license; and - Principles of person-centered planning/service delivery. ULP-J ULP-J was hired November 10, 2024, to provide direct cares and services to residents. ULP-J's employee records lacked orientation to assisted living regulations to include the following: - Assisted Living Bill of Rights; -Handing of resident complaints, reporting of	01470		

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01470	Continued From page 36 complaints, where to report; and - Review of types of Assisted Living services the employee will provide and provider's scope of license. ULP-L ULP-L was agency staff that was contracted into the facility on November 23, 28, and December 1, 2024, to provide direct cares and services to residents. ULP-L's employee records lacked orientation to assisted living regulations to include the following: - Overview of Assisted Living statutes; - Review of provider's policies and procedures; - Handling emergencies and using emergency services; - Reporting maltreatment of vulnerable adults or minors; - Assisted Living Bill of Rights; - Handing of resident complaints, reporting of complaints, where to report; - Consumer advocacy services; - Review of types of Assisted Living services the employee will provide and provider's scope of license; - Principles of person-centered planning/service delivery; - Orientation to each specific resident and services provided; and - Dementia training required for all direct care staff and supervisors. ULP-M ULP-M was agency staff that was contracted into the facility on November 7, 8, 10, 11, 21,22, and 24, 2024, to provide direct cares and services to residents. ULP-M's employee records lacked orientation to	01470		

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01470	Continued From page 37 assisted living regulations to include the following: - Review of provider's policies and procedures; - Handing of resident complaints, reporting of complaints, where to report; - Consumer advocacy services; - Review of types of Assisted Living services the employee will provide and provider's scope of license; - Principles of person-centered planning/service delivery; - Orientation to each specific resident and services provided; and - Dementia training required for all direct care staff and supervisors. ULP-N ULP-N was agency staff that was contracted into the facility on November 26, 2024, to provide direct cares and services to residents. ULP-N's employee records lacked orientation to assisted living regulations to include the following: - Overview of Assisted Living statutes; - Review of provider's policies and procedures; - Handling emergencies and using emergency services; - Reporting maltreatment of vulnerable adults or minors; - Assisted Living Bill of Rights; - Handing of resident complaints, reporting of complaints, where to report; - Consumer advocacy services; - Review of types of Assisted Living services the employee will provide and provider's scope of license; - Principles of person-centered planning/service delivery; - Orientation to each specific resident and services provided; and - Dementia training required for all direct care	01470		

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01470	Continued From page 38 staff and supervisors. ULP-O ULP-O was agency staff that was contracted into the facility on November 3, 5, 9, 11, 16, and 30, 2024, to provide direct cares and services to residents. ULP-O's employee records lacked orientation to assisted living regulations to include the following: - Review of provider's policies and procedures; - Handing of resident complaints, reporting of complaints, where to report; - Consumer advocacy services; - Review of types of Assisted Living services the employee will provide and provider's scope of license; - Principles of person-centered planning/service delivery; - Orientation to each specific resident and services provided; and - Dementia training required for all direct care staff and supervisors. ULP-P ULP-P was agency staff that was contracted into the facility on November 3, 11, 15, 18, 25, and 26, 2024, to provide direct cares and services to residents. ULP-P's employee records lacked orientation to assisted living regulations to include the following: - Overview of Assisted Living statutes; - Review of provider's policies and procedures; - Handling emergencies and using emergency services; - Reporting maltreatment of vulnerable adults or minors; - Assisted Living Bill of Rights; - Handing of resident complaints, reporting of	01470		

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OKALEE OF MEDINA	4350 CHIPPEWA COURT MEDINA, MN 55340

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01470	Continued From page 39 complaints, where to report; - Consumer advocacy services; - Review of types of Assisted Living services the employee will provide and provider's scope of license; - Principles of person-centered planning/service delivery; - Orientation to each specific resident and services provided; and - Dementia training required for all direct care staff and supervisors. On December 3, 2024, at 3:45 p.m., interim clinical nurse supervisor (ICNS)-D stated, "There is no training for the contract staff, they are given a packet that gives them access to charting, but other than that they do not get trained by an RN, they are assumed to be competency trained by the agency they work for." On December 3, 2024, at 3:50 p.m., licensed assisted living director (LALD)-C stated, "They are given a packet when they come in it's in the nurse's office. The agency gives them instructions where to find the packet that gives them passwords to get in." When asked if they have been given any training to the facility or competency trained, she stated "No, it is my understanding the agency competency trains them." On December 3, 2024, at 4:14 p.m., LALD-C sent an email that read, "We do not have agency files on individuals." On December 5, 2024, at 2:45 p.m., LALD-C stated, "I have given you all the trainings for orientation that I can find, so if you are missing it, I can't find anything more so we will have to assume it wasn't done or at least not	01470		

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01470	Continued From page 40 documented." When asked if this is a systemic issue LALD-C said "Probably, yes." The licensee's Orientation and annual training policy, dated March 29, 2019, indicated "All staff would complete an orientation to the assisted living ;licensing requirements and regulations before providing assisted living services to clients." No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
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	01620		

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01620	Continued From page 41 prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted an admission assessment and ongoing nursing assessments not to exceed every 90-days for two of two residents (R4 and R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents) The findings include: R4 R4 was admitted to the licensee and began receiving services on July 7, 2024. R4's diagnoses included Type 2 diabetes mellitus, osteoarthritis, Chronic atrial fibrillation, congestive heart failure, and hypertension. R4's Resident Service Agreement dated July 6, 2024, indicated R4 received monthly vitals, morning/evening (AM/PM) cares, bathing, assist of one with ambulation, toileting, escorts, compression stockings, laundry, wound care, and medication administration.	01620		

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01620	Continued From page 42 R4 had comprehensive assessments opened in the electronic charting system on June 18, 2024, July 31, 2024, August 14, 2024, and September 18, 2024. All of the assessments were signed on October 6, 2024, 91 days had passed without a completed assessment. R5 R5 was admitted to the licensee and began receiving services on August 1, 2024. R5's diagnoses included anxiety disorder, supraventricular tachycardia, gastro-esophageal reflux disease, and major depressive disorder. R5's unsigned signed service plan, indicated R5 received services including AM/PM cares, weekly shower, laundry, medication administration, toileting, and transfer assistance. R5's record included a comprehensive assessment dated November 20, 2024, 112 days had passed without an assessment completed. On December 5, 2024, at 4:21 p.m., interim clinical nurse supervisor (ICNS)-D stated, "We are trying to get the extra RN to get them caught up because they are all behind and need to get caught up." The licensee's Initial, Ongoing and Change in Condition Assessment - Evaluation of Residents policy dated February 27, 2020, indicated assessments would be completed upon admission, after 14 days of services, with a change of condition, and no less than every 90 days. No further information provided.	01620		

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01620	Continued From page 43 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01750 SS=I	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure prior to delegating the task of medication administration, the unlicensed personnel (ULP) were trained in the proper methods to perform the task or procedure for each resident and were able to demonstrate, to the registered nurse (RN), the ability to competently follow the procedure for three of five employees (ULP-L, ULP-N and ULP-P). 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	01750		

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01750	Continued From page 44 has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-L was contracted to work for the licensee to provide direct cares including medication and/or treatment administration on November 20, 22, 23, 29, 2024, as well as December 2, 4, 2024. On December 4, 2024, at 7:22 a.m. surveyor observed ULP-L to be working for the licensee. ULP-N was contracted to work for the licensee to provide direct cares including medication and/or treatment administration on November 26, 2024. ULP-P was contracted to work for the licensee to provide direct cares including medication and/or treatment administration on November 1, 4, 11, 15, 18, 19, 25, 26, 2024. The licensee lacked any employee records for ULP-L, ULP-M, ULP-N, ULP-O, and ULP-P. On December 3, 2024 at 3:45 p.m., interim clinical nurse supervisor (ICNS)-D stated, "There is no training for the contract staff, they are given a packet that gives them access to charting, but other than that they do not get trained by an RN, they are assumed to be competency trained by the agency they work for." On December 3, 2024, at 3:50 p.m., licensed assisted living director (LALD)-C stated, "They are given a packet when they come in it's in the nurse's office. The agency gives them instructions where to find the packet that gives them passwords to get in." When asked if they have been given any training to the facility or	01750		

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01750	Continued From page 45 competency trained, she stated "No, it is my understanding the agency competency trains them." On December 3, 2024, at 4:14 p.m., LALD-C sent an email that read, "We do not have agency files on individuals." The licensees Delegation of Nursing Tasks policy dated August 1, 2024, read, "Steps Prior to Delegating Medication Administration. A Registered Nurse may delegate medication administration to unlicensed personnel only after the RN has: a. Instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; b. Developed specific written instructions for each client and documented those instructions in the client's medication record/MAR; and c. Communicated with the unlicensed personnel about the individual needs of the client." No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE	01750		
01760 SS=F	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	01760		

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01760	Continued From page 46 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 medication was administered as prescribed for three of three residents (R4, R5 and R6). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R4 R4 was admitted to the licensee and began receiving services on July 7, 2024. R4's diagnoses included Type 2 diabetes mellitus, osteoarthritis, Chronic atrial fibrillation, congestive heart failure, and hypertension. R4's Resident Service Agreement dated July 6, 2024, indicated R4 received monthly vitals, morning/evening (AM/PM) cares, bathing, assist of one with ambulation, toileting, escorts, compression stockings, laundry, wound care, and medication administration.	01760		

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01760	Continued From page 47 R4's Med Admin Summary - Actual - Month report dated November 1, 2024, through November 30, 2024, indicated staff did not administer the following with no reason documented: -1:00 p.m., bumetanide one milligram (mg) once daily. R5 R5 was admitted to the licensee and began receiving services on August 1, 2024. On December 3, 2024, at 8:28 a.m., surveyor obseved ULP-B assisted R5 with eye drops. R5's diagnoses included anxiety disorder, supraventricular tachycardia, gastro-esophageal reflux disease, and major depressive disorder. R5's unsigned signed service plan, indicated R5 received services including AM/PM cares, weekly shower, laundry, medication administration, toileting, and transfer assistance. R5's Med Admin Summary - Actual - Month report dated November 1, 2024, through November 30, 2024, indicated staff did not administer the following with no reason documented: -6:15 a.m., Atropine Sulfate 1 percent (%) instill one drop in right eye once daily om November 4, 2024. -7:15 a.m., acetaminophen give two tabs (1000mg) by mouth three times daily, bupropion hydrochloride 300 mg once daily, clindamycin 1% between toes twice daily, clopidogrel bisulphate 75 mg give one tab by mouth daily, Dorzolamide/Timolol Maleate 2-0.5% instill 1 drop in both eyes twice daily, magnesium 500 mg once daily, pantoprazole 20mg daily, and Vitamin D 2000 units (U) on November 17 and 30, 2024.	01760		

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01760	Continued From page 48 -8:00 a.m., Refresh 1.4-0.6% one eye drop into each eye four times a day, on November 10 and 17, 2024. -12:00 p.m., Refresh 1.4-0.6% one eye drop into each eye four times a day, on November 17, 2024. -1:00 p.m., brimonidine tartrate 0.2% one drop into both eyes daily, Dorzolamide/Timolol Maleate 2-0.5% instill 1 drop in both eyes twice daily, duloxetine Hydrochloride 60 mg, take one capsule by mouth once daily one November 17, 2024. -4:00 p.m., prednisolone 1% into right eye daily on November 26, 2024. R6 R6 was admitted to the licensee and began receiving services on November 11, 2024. R6's diagnoses included type 2 diabetes, hypertension, bipolar disorder, and mild persistent asthma. R6's signed Service Plan - Modification dated November 13, 2024, indicated R6 received housekeeping, laundry, and medication administration. R6's Med Admin Summary - Actual - Month report dated November 1, 2024, through November 30, 2024, indicated staff did not administer the following with no reason documented: -9:00 a.m., Accolate 20 mg once daily, Breo Ellipta .01 microgram, (mcg) daily, Lantus 65u, omeprazole 40 mg once daily, pioglitazone 15 mg once daily, rivastigmine 13 mg apply one patch daily, and valsartan 160 mg once daily, on November 12 and 13, 2024. On December 5, 2024, at 4:05 p.m., interim	01760		

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01760	Continued From page 49 clinical nurse supervisor (ICNS)-D stated, "I assumed we were reviewing missed med and service recap, but I was not aware that it was set up for only doing last 24 hours so we may have missed some." The licensee's Charting and Documentation policy, dated March 13, 2023, indicated all services provided would be documented in the residents electronic chart. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
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: Based on observation, interview, and record review, the licensee failed to ensure prescription medications were securely locked in a substantially constructed compartment and permitted only authorized personnel to have access. 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	01880		

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01880	Continued From page 50 problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On December 3, 2024, at 7:45 a.m., the surveyor observed memory care assisted living medication cart that contained all medication for the memory care assisted living residents receiving medication administration services. The cart was located in the common area, just off the dining room in the memory care unit and was observed to be unlocked and unattended, with push lock unsecured. Unlicensed personnel (ULP) were away from the medication carts, tending to other tasks around the unit. Next to the medication cart was the door to the office which was left open, unlocked, and unattended. Inside the office was an unlocked cabinet that had a shower caddy with nystatin prescription powder for one resident. One therapy staff member was in the common area as well as one resident. On December 3, 2024, at 7:45 a.m., unlicensed personnel (ULP)-B stated, "We lock the cart after every medication count, but we have more than one person that does med pass so we all have access to unlock the cart." On December 3, 2024, at 7:59 a.m., ULP-B locked the medication cart and placed the keys on the side of the cart in the cup holder, there were three residents around in common area dining room. On December 3, 2024, at 8:40 a.m., ULP-B locked the medication cart and placed the keys on the side of the cart in the cup holder, there were three employees around and seven	01880		

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01880	Continued From page 51 residents in common area eating. On December 3, 2024, at 10:23 a.m, interim clinical nurse supervisor (ICNS)-D stated, "The process that they use for storing medications is they have the med cart in memory care and they are locked and secured there, unless they have orders to self-administer. The blister cards come from [pharmacy] and those are locked in the med cart and in the nurse office, there is a locker that is in the nurse office and all medication cabinets need to be secured." The licensee's Medication storage policy dated, December 18, 2019, indicated medications would be kept in locked storage when not in use, and when not locked they would not be left unattended. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of	01910		

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01910	Continued From page 52 medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide documentation in the resident's record regarding the disposition of medication to include the medication strength, prescription number, quantity, date of disposition, and names of staff and other individuals involved in the disposition for one of three discharged residents (R8). 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: R8 was admitted to the licensee on October 18, 2021, and discharged on October 31, 2024. R8's Discharge Care Plan, indicated R1 received services including assistance with housekeeping, laundry, grooming, bathing, assistance with medication administration, and mobility assistance.	01910		

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01910	Continued From page 53 R8's record lacked a medication disposition to include the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. On December 4, 2024, at 12:44 p.m., interim clinical nurse supervisor (ICNS)-D stated, "I did not find anything on [R8's] for discharge and disposition of medications, I did find an admission assessment for her that was never completed. No idea why they wouldn't have done these, as it is needed for a discharge." The licensee's was unable to provide a policy related to disposition of medications to the surveyor. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
01950 SS=I	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health	01950		

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	35700	A. BUILDING: _____ B. WING _____	12/06/2024

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01950	Continued From page 54 professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure prior to delegating nursing tasks of treatment administration, the unlicensed personnel (ULP) were trained in the proper methods to perform the task or procedure for each resident, and were able to demonstrate, to the registered nurse (RN), the ability to competently follow the procedure for five of five employees (ULP-L, ULP-M, ULP-N, ULP-O, and ULP-P). This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-L was contracted to work for the licensee to provide direct cares including medication and/or treatment administration on November 20, 22, 23, 29, 2024, as well as December 2, 4, 2024. On December 4, 2024, at 7:22 a.m. surveyor	01950		

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01950	Continued From page 55 observed ULP-L to be working for the licensee. ULP-M was contracted to work for the licensee to provide direct cares including medication and/or treatment administration on November 20, 22, 23, 29, 2024. ULP-N was contracted to work for the licensee to provide direct cares including medication and/or treatment administration on November 26, 2024. ULP-O was contracted to work for the licensee to provide direct cares including medication and/or treatment administration on November 3, 5, 6, 9, 10, 11, 16, 30 2024. ULP-P was contracted to work for the licensee to provide direct cares including medication and/or treatment administration on November 1, 4, 11, 15, 18, 19, 25, 26, 2024. The licensee lacked any employee records for ULP-L, ULP-M, ULP-N, ULP-O, and ULP-P. On December 3, 2024 at 3:45 p.m., interim clinical nurse supervisor (ICNS)-D stated, "There is no training for the contract staff, they are given a packet that gives them access to charting, but other than that they do not get trained by an RN, they are assumed to be competency trained by the agency they work for." On December 3, 2024, at 3:50 p.m., licensed assisted living director (LALD)-C stated, "They are given a packet when they come in it's in the nurse's office. The agency gives them instructions where to find the packet that gives them passwords to get in." When asked if they have been given any training to the facility or competency trained, she stated "No, it is my	01950		

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01950	Continued From page 56 understanding the agency competency trains them." On December 3, 2024, at 4:14 p.m., LALD-C sent an email that read, "We do not have agency files on individuals." The licensees Delegation of Nursing Tasks policy dated August 1, 2024, read, "Steps Prior to Delegating Administration of Treatments and Therapy. Treatments or therapy tasks may be delegated or assigned by a Licensed Health Professional to unlicensed personnel according to the Licensed Health Professional's applicable licensing practice standards. When a treatment or therapy is delegated or assigned to unlicensed personnel, the RN or authorized Licensed Health Professional must: a. Develop and maintain a current individualized treatment or therapy management record for each client that addresses the Statutes to the specific state (sic) b. Instruct the unlicensed personnel in the proper methods to provide the treatment or perform the task with respect to each client and determine that the unlicensed personnel have demonstrated the ability to competently follow the procedures: c. Develop written specific instructions for each client and document those instructions in the client's record; and d. Communicated with the unlicensed personnel about the individual needs of the client." No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE	01950		
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments	01960		

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01960	Continued From page 57 Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure treatments were performed as ordered for two of three residents (R4 and R5). 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: R4 R4 was admitted to the licensee and began receiving services on July 7, 2024. R4's diagnoses included Type 2 diabetes mellitus, osteoarthritis, Chronic atrial fibrillation, congestive heart failure, and hypertension. R4's Resident Service Agreement dated July 6,	01960		

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01960	Continued From page 58 2024, indicated R4 received monthly vitals, morning/evening (AM/PM) cares, bathing, assist of one with ambulation, toileting, escorts, compression stockings, laundry, wound care, and medication administration. R4's Service Recap Summary - Month for November 2024, had the following missing charting: - Safety check for 12:00 a.m., on November 2, 2024, - Safety check for 2:00 a.m., on November 2, 2024, - Toileting for 2:00 a.m., on November 2, 2024, - Safety check for 4:00 a.m., on November 2, 2024, - Behavior check for 6:30 a.m., on November 2 and 4, 2024, - Safety check for 7:00 a.m., on November 8, 17, 28, and 30, 2024, - Weight recorded for 7:15 a.m., on November 8, 17, 28, and 30, 2024, - AM cares for 8:00 a.m., on November 8, 17, 28, and 30, 2024, - Bathing assistance for 8:00 a.m., on November 18, 2024, - Escort for 8:00 a.m., on November 8, 17, and 30, 2024, - Toileting for 8:00 a.m., on November 8, 17, 28, and 30, 2024, - Compression stockings for 8:00 a.m., on November 8, 17, 28, and 30, 2024, - Escort for 10:00 a.m., on November 8, 17, and 30, 2024, - Blood pressure for 8:00 a.m., on November 4, 2024, - Toileting for 10:00 a.m., on November 8, 17, 28, and 30, 2024, - Escort for 12:00 p.m., on November 8, 17, 21, and 30, 2024,	01960		

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01960	Continued From page 59 - Behavior check for Midday, on November 17, 2024, - Toileting for 1:00 p.m., on November 8, 17, 21, 28, and 30, 2024, - Escort for 2:00 p.m., on November 8, 17, 21, and 30, 2024, - Housekeeping for 2:30 p.m., on November 8, 9, 11, 17, 21, 28, and 30, 2024, - Toileting for 2:45 p.m., on November 8, 9, 11, 17, 21, 28, and 30, 2024, - Escort for 5:00 p.m., on November 1, 6, 20, and 26, 2024, - Toileting for 5:00 p.m., on November 1, 4, 6, 11, 20, and 26, 2024, - Linen change for 6:00 p.m. on November 1, 2024, - Toileting for 7:00 p.m., on November 1, 4, 6, 11, 13, 20, and 26, 2024, - Laundry for 6:00 p.m. on November 1, 2024, - Compression stockings for 7:45 p.m., on November 1, 4, 6, 11, 13, 20, and 26, 2024, - PM cares for 7:45 p.m., on November 1, 4, 6, 11, 13, 20, and 26, 2024, - Housekeeping for 8:30 p.m., on November 1, 4, 6, 11, 13, 20, 25 and 26, 2024, - Behavior check for 10:30 p.m., on November 1, 3, 6, 11, 12, and 26, 2024, and - Safety check for 10:30 p.m., on November 1, 3, 6, 11, 12, 13, 20, 25 and 26, 2024. R5 R5 was admitted to the licensee and began receiving services on August 1, 2024. R5's diagnoses included anxiety disorder, supraventricular tachycardia, gastro-esophageal reflux disease, and major depressive disorder. R5's unsigned signed service plan, indicated R5 received services including AM/PM cares, weekly	01960		

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01960	Continued From page 60 shower, laundry, medication administration, toileting, and transfer assistance. R5's Service Recap Summary - Month for November 2024, had the following missing charting: - Safety check for 12:00 a.m., on November 2, 2024, - CPAP/BIPAP for 2:00 a.m., on November 2, 2024, - Safety check for 2:00 a.m., on November 2, 2024, - Safety check for 4:00 a.m., on November 2, 2024, - Safety check for 6:00 a.m., on November 2, 2024, -Transfer assistance for 7:00 a.m., on November 8, 17, and 30, 2024, - Housekeeping for AM, on November 13, 2024, - Safety check for 7:15 a.m., on November 8, 17, 28, and 30, 2024, - Toileting for 9:00 a.m., on November 8, 17, and 30, 2024, - AM cares for 9:15 a.m., on November 8, 17, 28, and 30, 2024, - CPAP/BIPAP for 9:15 a.m., on November 8, 17, 28, and 30, 2024, - Hearing aids for 9:15 a.m., on November 8, 17, and 30, 2024, - Escort for 10:00 a.m., on November 8, 17, 28, and 30, 2024, - Nail care for 11:00 a.m., on November 21 and 28, 2024, - Toileting for 11:00 a.m., on November 8, 17, and 30, 2024, - Escort for 11:45 a.m., on November 8, 17, 28, and 30, 2024, - Record pain for 1:00 p.m., on November 8, 17, 28, and 30, 2024, - Toileting for 1:00 p.m., on November 8, 17, 21	01960		

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01960	Continued From page 61 and 30, 2024, - Bathing assistance for 1:30 p.m., on November 21, 2024, - Hydration for 1:30 p.m., on November 8, 17, 28, and 30, 2024, - Escort for 2:00 p.m., on November 8, 17, 28, and 30, 2024, - Safety check for 2:00 p.m., on November 8, 17, 28, and 30, 2024, - Toileting for 3:00 p.m., on November 6, 8, 9, 10, 11, 17, 21 and 30, 2024, - Transfer assistance for 3:00 p.m., on November 1, 6, 22-30, 2024, - Transfer assistance for 4:00 p.m., on November 1-21, 2024, - Hydration for 4:30 p.m., on November 1-3, 2024, - Escort for 4:45 p.m., on November 1-3, 2024, - Safety check for 5:00 p.m., on November 1-3, 2024, - Housekeeping for 6:00 p.m. on November 1 and 3, 2024, - Toileting for 6:00 p.m., on November 3 and 16, 2024, - Hearing aids for 7:00 p.m., on November 3 and 4, 2024, - Safety check for 8:00 p.m., on November 1-4, 2024, - Toileting for 8:00 p.m., on November 3, 4, and 16, 2024, - Safety check for 8:45 p.m., on November 1-4, 6, and 25, 2024, - PM cares for 8:55 p.m., on November 1-4, 6, and 25, 2024, - Toileting for 10:00 p.m., on November 1, 6, 11-13, 20. 25 and 26, 2024, - Safety check for 11:30 p.m., on November 1, 2024, and - Transfer assistance for 11:30 p.m., on November 1, 2024.	01960		

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01960	Continued From page 62 On December 5, 2024, at 4:05 p.m., interim clinical nurse supervisor (ICNS)-D stated, "I assumed we were reviewing missed med and service recap, but I was not aware that it was set up for only doing last 24 hours so we may have missed some." The licensee's Charting and Documentation policy, dated March 13, 2023, indicated all services provided would be documented in the residents electronic chart. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to provide hazard vulnerability assessment or safety risk assessment of the	02040		

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02040	Continued From page 63 physical environment on and around the property for the facility. This deficient practice had the ability 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 December 03, 2024, at 11:30 a.m. with executive director (ED)-F, on the hazard vulnerability assessment for the physical environment of the facility. Record review indicated that the licensee had not performed a hazard vulnerability assessment with mitigation factors on and around the property. During interview, ED-F stated he understood the requirements of this policy. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		
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.	02310		

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02310	Continued From page 64 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 three of three residents (R4, R5 and R10) with hospital-style 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). The findings include: R4 R4 admitted to the licensee and began receiving services on July 7, 2024. R4 had diagnoses to include type 2 diabetes, hypertension, atrial fibrillation, and congestive heart failure. R4's undated and unsigned Service Plan, indicated R4 received assistance with AM cares, bathing assistance, compression stockings, mobility assistance, housekeeping, laundry, linen change, medication administration, nail care, PM cares, monthly vitals, daily weights, and toileting. On December 3, 2024, at 8:06 a.m., surveyor observed R4's bed had bilateral (two sides) half rail hospital-style bed rails located at the head of	02310		

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02310	Continued From page 65 the hospital bed. The bed rails were firmly attached to the bed. On December 3, 2024, at 8:06 a.m., R4 stated, "I use them all the time." R4's record included a document titled [licensee] Bed Safety Assessment Form dated October 10, 2024, which lacked; - 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; - The resident's preferences; - Installation and use according to manufacturer's guidelines; - documentation of physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; - documentation the licensee explained the risks of the bed rail usage with the resident and/or the resident's representative; - evidence the licensee measured the bed rail zones of entrapment; and - any necessary information related to interventions to mitigate safety risk or negotiated risk agreements". R5 R5 admitted to the licensee and began receiving services on August 1, 2024. R5 had diagnoses to include fibromyalgia, hypertension, anxiety, and rheumatoid arthritis. R5's Resident Service Agreement, dated July 6, 2024, indicated R5 received assistance with AM cares, bathing assistance, compression stockings, dining escort, housekeeping, linen change, medication administration, ambulation	02310		

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OKALEE OF MEDINA	4350 CHIPPEWA COURT MEDINA, MN 55340

(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 66 physical assist of one, wound care, PM cares, monthly vitals, daily weight monitoring and toileting. R5's record included a document titled [licensee] Bed Safety Assessment Form dated November 20, 2024, which lacked; - 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; - The resident's preferences; - Installation and use according to manufacturer's guidelines; - documentation of physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; - documentation the licensee explained the risks of the bed rail usage with the resident and/or the resident's representative; - evidence the licensee measured the bed rail zones of entrapment; and - any necessary information related to interventions to mitigate safety risk or negotiated risk agreements". R10 R10 admitted to the licensee and began receiving services on July 27, 2022. R10 had diagnoses to include Alzheimer's disease, kidney disease, osteoarthritis, and major depressive disorder. R10's undated and unsigned Service Plan, indicated R10 received assistance with AM cares, bathing assistance, bedmaking, mobility assistance, housekeeping, laundry, linen change, medication administration, PM cares, monthly vitals, and toileting.	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35700	A. BUILDING: _____ B. WING _____	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OKALEE OF MEDINA	4350 CHIPPEWA COURT MEDINA, MN 55340

(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 67 R10's record lacked a Bed Safety Assessment Form to address; - 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; - The resident's preferences; - Installation and use according to manufacturer's guidelines; - documentation of physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; - documentation the licensee explained the risks of the bed rail usage with the resident and/or the resident's representative; - evidence the licensee measured the bed rail zones of entrapment; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements". On December 4, 2024, at 1:59 p.m., interim clinical nurse supervisor (ICNS)-D indicated that what was noted above was all that was recorded for each resident, and stated, "If [bedrail assessments] are not in Rtasks (an electronic charting system used by licensee) than they wouldn't be anywhere else." On December 4, 2024, at 12:40 p.m. ICNS-D stated, "At this time we have not found the policies, so I am unsure if there is one, but I can keep looking, or we can get one made." 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	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35700	A. BUILDING: _____ B. WING _____	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OKALEE OF MEDINA	4350 CHIPPEWA COURT MEDINA, MN 55340

(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 68 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 March 10, 2006, FDA Side Rail Entrapment Zones and Dimensional Recommendations indicated to reduce the risk of entrapment, zone 1 (within the rail) should not exceed 4 and 3/4 inches, zone 2 (under the rail, between rail supports or next to a single rail support) should not exceed 4 and 3/4 inches, zone 3 (between the rail and the mattress), should not exceed 4 and 3/4 inches, and zone 4 (under the rail, at the ends of the rail) should not exceed 2 and 3/8 inches or be greater than a 60 degree angle. 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:	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35700	A. BUILDING: _____ B. WING _____	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OKALEE OF MEDINA	4350 CHIPPEWA COURT MEDINA, MN 55340

(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 69 - 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. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	02310		

Minnesota Department of Health

625 North Robert Street
Saint Paul, MN
651-201-5000

Type: Full
Date: *12/03/24*
Time: 15:00:00
Report: 8087241282

Food and Beverage Establishment Inspection Report

Location:
Okalee Of Medina
4350 Chippewa Court
Medina, MN55340
Hennepin County, 27

Establishment Info:
ID #: 0038741
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7637625400
ID #:

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

The following orders were issued during this inspection.

2-100 Supervision

2-102.12AMN

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

THERE IS NO FULL TIME STATE CERTIFIED FOOD PROTECTION MANAGER AT THE ESTABLISHMENT. HIRE A FULL TIME EMPLOYEE OR TRAIN AN EXISTING FULL TIME EMPLOYEE AND APPLY FOR THE STATE CERTIFIED FOOD PROTECTION MANAGER CERTIFICATE.

Comply By: 03/01/25

4-500 Equipment Maintenance and Operation

4-501.11AB

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

RINSE WATER TEMPERATURE GAUGE ON THE DISH MACHINE IS NOT FUNCTIONING. REPAIR OR REPLACE THE TEMPERATURE GAUGE TO COMPLY WITH THE RULE ABOVE.

Comply By: 01/01/25

Surface and Equipment Sanitizers

Quaternary Ammonia: = 400 PPM at -- Degrees Fahrenheit
Location: WALL DISPENSING UNIT
Violation Issued: No

Quaternary Ammonia: = 200 PPM at -- Degrees Fahrenheit
Location: WIPING CLOTH BUCKET
Violation Issued: No

Wash Temperature Gauge: = -- at 113 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Max Utensil Surface Temp: = -- at 162 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Ambient Air
Temperature: -5 Degrees Fahrenheit - Location: STAND-UP FREEZER
Violation Issued: No

Process/Item: Ambient Air
Temperature: 35 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

Process/Item: Cold Holding: CHICKEN
Temperature: 35 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

Process/Item: Cold Holding: RICE
Temperature: 35 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

Process/Item: Cold Holding: SOUP
Temperature: 36 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

Process/Item: Cold Holding: CHEESE
Temperature: 36 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

Process/Item: Cold Holding: CUT TOMATO
Temperature: 35 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

Process/Item: Cold Holding: DELI MEAT
Temperature: 34 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

Process/Item: Hot Holding: POTATO
Temperature: 156 Degrees Fahrenheit - Location: SERVICE LINE WARMING WELL
Violation Issued: No

Process/Item: Hot Holding: GRAVY
Temperature: 171 Degrees Fahrenheit - Location: SERVICE LINE WARMING WELL
Violation Issued: No

Process/Item: Cold Holding: HB EGG
Temperature: 39 Degrees Fahrenheit - Location: PREP COOLER
Violation Issued: No

Type: Full
Date: *12/03/24*
Time: 15:00:00
Report: 8087241282
Okalee Of Medina

Food and Beverage Establishment Inspection Report

Process/Item: Cold Holding: DELI MEAT
Temperature: 40 Degrees Fahrenheit - Location: PREP COOLER
Violation Issued: No

Process/Item: Cold Holding: CUT TOMATO
Temperature: 39 Degrees Fahrenheit - Location: PREP COOLER
Violation Issued: No

Process/Item: Cold Holding: CHEESE
Temperature: 40 Degrees Fahrenheit - Location: PREP COOLER
Violation Issued: No

Process/Item: Cold Holding: CHIX SALAD
Temperature: 39 Degrees Fahrenheit - Location: PREP COOLER
Violation Issued: No

Process/Item: Ambient Air
Temperature: 36 Degrees Fahrenheit - Location: DISPLAY COOLER
Violation Issued: No

Process/Item: Cold Holding: CUT MELON
Temperature: 35 Degrees Fahrenheit - Location: DISPLAY COOLER
Violation Issued: No

Process/Item: Ambient Air
Temperature: -1 Degrees Fahrenheit - Location: ICE CREAM FREEZER
Violation Issued: No

Process/Item: Ambient Air
Temperature: -8 Degrees Fahrenheit - Location: WALK-IN FREEZER
Violation Issued: No

Process/Item: Hot Holding: SOUP
Temperature: 161 Degrees Fahrenheit - Location: SOUP WARMER
Violation Issued: No

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

THIS WAS AN UNANNOUNCED AND UNSCHEDULED FULL INSPECTION.

INSPECTION DONE WITH MANAGER BRITTNEY HOLM.

TOPICS OF DISCUSSION WITH OPERATOR INCLUDED:

HAND WASHING
NOROVIRUS
BARE HAND CONTACT WITH READY TO EAT FOODS
EMPLOYEE ILLNESS
EMPLOYEE EXCLUSION
COOLING METHODS
REHEATING METHODS
SANITIZER CONCENTRATION
DATE MARKING

ALL ITEMS ON THIS REPORT
ALL ITEMS ON PREVIOUS REPORT

ALL FROZEN FOODS FOUND IN FROZEN CONDITION.

REPORT EMAILED TO HRD NURSING SURVEYOR TESA BROWN AND TO THE ESTABLISHMENT.

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 8087241282 of 12/03/24.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /_____

Inspection report reviewed with person in charge and emailed.

Signed:_____

BRITTNEY HOLM
MANAGER

Signed:_____

John Boettcher
Public Health Sanitarian 3
St. Paul, MN / Freeman
651-201-5076
john.boettcher@state.mn.us