



*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically Delivered

November 18, 2025

Licensee  
Harding Place  
24448 296th Avenue  
Pierz, MN 56364

RE: Project Number(s) SL34822015

Dear Licensee:

On November 13, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on July 11, 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,

A handwritten signature in black ink, appearing to read 'Tim Hanna'.

Tim Hanna, Supervisor  
State Engineering Services Section  
Email: Tim.Hanna@state.mn.us  
Telephone: 507-208-8982 Fax: 1-866-890-9290

CLN





*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically Delivered

October 23, 2025

Licensee  
Harding Place  
24448 296th Avenue  
Pierz, MN 56364

RE: Project Number(s) SL34822015

Dear Licensee:

On July 22, 2025, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on July 11, 2024. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the July 11, 2024 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on July 11, 2024, found not corrected at the time of the July 22, 2025, follow-up survey and/or subject to penalty assessment are as follows:

**0830-Local Laws Apply-144g.45 Subd. 3 - \$500.00**

The details of the violations noted at the time of this follow-up survey completed on July 22, 2025 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

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

**DOCUMENTATION OF ACTION TO COMPLY**

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

**IMPOSITION OF FINES**

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;

Level 3: a fine of \$1,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;

Level 4: a fine of \$3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;



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

#### **CORRECTION ORDER RECONSIDERATION PROCESS**

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

To submit a reconsideration request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

#### **REQUESTING A HEARING**

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

To submit a hearing request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

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

We urge you to review these orders carefully. If you have questions, please contact Benjamin J. Zwart at 651-201-3715.

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

Sincerely,



Benjamin J. Zwart, Supervisor  
State Engineering Services Section  
Email: Benjamin.Zwart@state.mn.us  
Telephone: 651-201-3715 Fax: 1-800-337-9238 / 1-866-890-9290

HHH



Minnesota Department of Health

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                        |                                                                                                                          |  |                                                                    |
|----------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34822</b>              | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>07/22/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HARDING PLACE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>24448 296TH AVENUE<br/>PIERZ, MN 56364</b> |                                                                                                                          |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ID<br>PREFIX<br>TAG                                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                           |
| {0 000}                                                  | Initial Comments<br><br>*****ATTENTION*****<br><br>ASSISTED LIVING PROVIDER LICENSING<br>CORRECTION ORDER<br><br>In accordance with Minnesota Statutes, section<br>144G.08 to 144G.95 this correction order(s) has<br>been issued pursuant to a survey.<br><br>Determination of whether a violation has been<br>corrected requires compliance with all<br>requirements provided at the Statute number<br>indicated below. When Minnesota Statute<br>contains several items, failure to comply with any<br>of the items will be considered lack of<br>compliance.<br><br>INITIAL COMMENTS:<br><br>SL#34822015-4<br><br>On July 22, 2025, through July 23, 2025, the<br>Minnesota Department of Health conducted a<br>follow-up survey at the above provider to<br>follow-up on orders issued pursuant to a survey<br>completed on April 25, 2025. As a result of the<br>follow-up survey, the following orders were<br>reissued. | {0 000}                                                                                |                                                                                                                          |  |                                                                    |
| {0 100}<br>SS=F                                          | 144G.10 Subdivision 1 License required<br><br>(a)(1) Beginning August 1, 2021, no assisted<br>living facility may operate in Minnesota unless it is<br>licensed under this chapter.<br>(2) No facility or building on a campus may<br>provide assisted living services until obtaining the<br>required license under paragraphs (c) to (e).<br>(b) The licensee is legally responsible for the                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | {0 100}                                                                                |                                                                                                                          |  |                                                                    |

Minnesota Department of Health

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

TITLE

(X6) DATE



Minnesota Department of Health

|                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                 |                                                                                                                          |                          |                                                   |
|---------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|---------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>34822 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |                          | (X3) DATE SURVEY COMPLETED<br><br>R<br>07/22/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>HARDING PLACE |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br>24448 296TH AVENUE<br>PIERZ, MN 56364                                           |                          |                                                   |
| (X4) ID<br>PREFIX<br>TAG                          | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ID<br>PREFIX<br>TAG                                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                   |
| {0 100}                                           | Continued From page 1<br><br>management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. Nothing in this chapter shall in any way affect the rights and remedies available under other law.<br>(c) Upon approving an application for an assisted living facility license, the commissioner shall issue a single license for each building that is operated by the licensee as an assisted living facility and is located at a separate address, except as provided under paragraph (d) or (e). If a portion of a licensed assisted living facility building is utilized by an unlicensed entity or an entity with a license type not granted under this chapter, the licensed assisted living facility must ensure there is at least a vertical two-hour fire barrier as defined by the National Fire Protection Association Standard 101, Life Safety Code, between any licensed assisted living facility areas and unlicensed entity areas of the building and between the licensed assisted living facility areas and any licensed areas subject to another license type.<br>(d) Upon approving an application for an assisted living facility license, the commissioner may issue a single license for two or more buildings on a campus that are operated by the same licensee as an assisted living facility. An assisted living facility license for a campus must identify the address and licensed resident capacity of each building located on the campus in which assisted living services are provided.<br>(e) Upon approving an application for an assisted living facility license, the commissioner may:<br>(1) issue a single license for two or more buildings on a campus that are operated by the same licensee as an assisted living facility with dementia care, provided the assisted living facility for dementia care license for a campus identifies | {0 100}                                                         |                                                                                                                          |                          |                                                   |



Minnesota Department of Health

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                        |                                                                                                                          |  |                                                                    |
|----------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34822</b>              | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>07/22/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HARDING PLACE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>24448 296TH AVENUE<br/>PIERZ, MN 56364</b> |                                                                                                                          |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | ID<br>PREFIX<br>TAG                                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                           |
| {0 100}                                                  | Continued From page 2<br><br>the buildings operating as assisted living facilities with dementia care; or<br>(2) issue a separate assisted living facility with dementia care license for a building that is on a campus and that is operating as an assisted living facility with dementia care.<br><br>This MN Requirement is not met as evidenced by:<br>Not reviewed during this survey.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | {0 100}                                                                                |                                                                                                                          |  |                                                                    |
| {0 460}<br>SS=F                                          | 144G.41 Subdivision 1 Minimum requirements<br><br>(5) provide a means for residents to request assistance for health and safety needs 24 hours per day, seven days per week;<br>(6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract;<br>(7) permit residents access to food at any time;<br>(8) allow residents to choose the resident's visitors and times of visits;<br>(9) allow the resident the right to choose a roommate if sharing a unit;<br>(10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living facility must not lock a resident in the resident's unit;<br><br>This MN Requirement is not met as evidenced by:<br>Not reviewed during this survey. | {0 460}                                                                                |                                                                                                                          |  |                                                                    |



Minnesota Department of Health

|                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                |                                                                                                                          |  |                                                   |
|---------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>34822                | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br>R<br>07/22/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>HARDING PLACE |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br>24448 296TH AVENUE<br>PIERZ, MN 56364 |                                                                                                                          |  |                                                   |
| (X4) ID<br>PREFIX<br>TAG                          | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                          |
| {0 470}                                           | Continued From page 3                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | {0 470}                                                                        |                                                                                                                          |  |                                                   |
| {0 470}<br>SS=F                                   | 144G.41 Subdivision 1 Minimum requirements<br><br>(11) develop and implement a staffing plan for determining its staffing level that:<br>(i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility;<br>(ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and<br>(iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility;<br>(12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be:<br>(i) awake;<br>(ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time;<br>(iii) capable of communicating with residents;<br>(iv) capable of providing or summoning the appropriate assistance; and<br>(v) capable of following directions;<br><br>This MN Requirement is not met as evidenced by:<br>Not reviewed during this survey. | {0 470}                                                                        |                                                                                                                          |  |                                                   |
| {0 480}<br>SS=F                                   | 144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services<br><br>(a) Except as provided in paragraph (b), food                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | {0 480}                                                                        |                                                                                                                          |  |                                                   |



Minnesota Department of Health

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                        |                                                                                                                          |  |                                                                    |
|----------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34822</b>              | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>07/22/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HARDING PLACE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>24448 296TH AVENUE<br/>PIERZ, MN 56364</b> |                                                                                                                          |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | ID<br>PREFIX<br>TAG                                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                           |
| {0 480}                                                  | <p>Continued From page 4</p> <p>must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626.</p> <p>(b) For an assisted living facility with a licensed capacity of ten or fewer residents:</p> <p>(1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation;</p> <p>(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;</p> <p>(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;</p> <p>(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;</p> <p>(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</p> | {0 480}                                                                                |                                                                                                                          |  |                                                                    |



Minnesota Department of Health

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                        |                                                                                                                          |  |                                                                    |
|----------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34822</b>              | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>07/22/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HARDING PLACE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>24448 296TH AVENUE<br/>PIERZ, MN 56364</b> |                                                                                                                          |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ID<br>PREFIX<br>TAG                                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                           |
| {0 480}                                                  | Continued From page 5<br><br>and in good condition;<br>(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<br>(7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door.<br><br>This MN Requirement is not met as evidenced by:<br>Not reviewed during this survey.                                                                                                                                                                                         | {0 480}                                                                                |                                                                                                                          |  |                                                                    |
| {0 640}<br>SS=F                                          | 144G.42 Subd. 7 Posting information for reporting suspected c<br><br>The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by:<br>(1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility;<br>(2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and<br>(3) providing reasonable accommodations with information and notices in plain language.<br><br>This MN Requirement is not met as evidenced by:<br>Not reviewed during this survey. | {0 640}                                                                                |                                                                                                                          |  |                                                                    |



Minnesota Department of Health

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                        |                                                                                                                          |  |                                                                    |
|----------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34822</b>              | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>07/22/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HARDING PLACE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>24448 296TH AVENUE<br/>PIERZ, MN 56364</b> |                                                                                                                          |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ID<br>PREFIX<br>TAG                                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                           |
| {0 650}                                                  | Continued From page 6                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | {0 650}                                                                                |                                                                                                                          |  |                                                                    |
| {0 650}<br>SS=F                                          | <b>144G.42 Subd. 8 (a) Staff records</b><br><br>(a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information:<br>(1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules;<br>(2) records of orientation, required annual training and infection control training, and competency evaluations;<br>(3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision;<br>(4) documentation of annual performance reviews that identify areas of improvement needed and training needs;<br>(5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and<br>(6) documentation of the background study as required under section 144.057.<br><br>This MN Requirement is not met as evidenced by:<br>Not reviewed during this survey. | {0 650}                                                                                |                                                                                                                          |  |                                                                    |
| {0 660}<br>SS=F                                          | <b>144G.42 Subd. 9 Tuberculosis prevention and control</b><br><br>(a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | {0 660}                                                                                |                                                                                                                          |  |                                                                    |



Minnesota Department of Health

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                        |                                                                                                                          |  |                                                                    |
|----------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34822</b>              | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>07/22/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HARDING PLACE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>24448 296TH AVENUE<br/>PIERZ, MN 56364</b> |                                                                                                                          |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ID<br>PREFIX<br>TAG                                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                           |
| {0 660}                                                  | Continued From page 7<br><br>and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines.<br>(b) The facility must maintain written evidence of compliance with this subdivision.<br><br>This MN Requirement is not met as evidenced by:<br>Not reviewed during this survey.                                                                                                                                                                                                                                                                | {0 660}                                                                                |                                                                                                                          |  |                                                                    |
| {0 680}<br>SS=F                                          | 144G.42 Subd. 10 Disaster planning and emergency preparedness<br><br>(a) The facility must meet the following requirements:<br>(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;<br>(2) post an emergency disaster plan prominently;<br>(3) provide building emergency exit diagrams to all residents;<br>(4) post emergency exit diagrams on each floor; and<br>(5) have a written policy and procedure regarding missing residents.<br>(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 | {0 680}                                                                                |                                                                                                                          |  |                                                                    |



Minnesota Department of Health

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                        |                                                                                                                          |  |                                                                    |
|----------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34822</b>              | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>07/22/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HARDING PLACE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>24448 296TH AVENUE<br/>PIERZ, MN 56364</b> |                                                                                                                          |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ID<br>PREFIX<br>TAG                                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                           |
| {0 680}                                                  | Continued From page 8<br><br>received emergency and disaster training are<br>allowed to work only when trained staff are also<br>working on site.<br>(c) The facility must meet any additional<br>requirements adopted in rule.<br><br>This MN Requirement is not met as evidenced<br>by:<br>Not reviewed during this survey.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | {0 680}                                                                                |                                                                                                                          |  |                                                                    |
| {0 730}<br>SS=F                                          | <b>144G.43 Subd. 3</b> Contents of resident record<br><br>Contents of a resident record include the<br>following for each resident:<br>(1) identifying information, including the resident's<br>name, date of birth, address, and telephone<br>number;<br>(2) the name, address, and telephone number of<br>the resident's emergency contact, legal<br>representatives, and designated representative;<br>(3) names, addresses, and telephone numbers of<br>the resident's health and medical service<br>providers, if known;<br>(4) health information, including medical history,<br>allergies, and when the provider is managing<br>medications, treatments or therapies that require<br>documentation, and other relevant health<br>records;<br>(5) the resident's advance directives, if any;<br>(6) copies of any health care directives,<br>guardianships, powers of attorney, or<br>conservatorships;<br>(7) the facility's current and previous<br>assessments and service plans;<br>(8) all records of communications pertinent to the<br>resident's services;<br>(9) documentation of significant changes in the<br>resident's status and actions taken in response to<br>the needs of the resident, including reporting to | {0 730}                                                                                |                                                                                                                          |  |                                                                    |



Minnesota Department of Health

|                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                 |                                                                                                                          |                          |                                                   |
|---------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|---------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>34822 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |                          | (X3) DATE SURVEY COMPLETED<br><br>R<br>07/22/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>HARDING PLACE |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br>24448 296TH AVENUE<br>PIERZ, MN 56364                                           |                          |                                                   |
| (X4) ID<br>PREFIX<br>TAG                          | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ID<br>PREFIX<br>TAG                                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                   |
| {0 730}                                           | Continued From page 9<br><br>the appropriate supervisor or health care professional;<br>(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;<br>(11) documentation that services have been provided as identified in the service plan;<br>(12) documentation that the resident has received and reviewed the assisted living bill of rights;<br>(13) documentation of complaints received and any resolution;<br>(14) a discharge summary, including service termination notice and related documentation, when applicable; and<br>(15) other documentation required under this chapter and relevant to the resident's services or status.<br><br>This MN Requirement is not met as evidenced by:<br>Not reviewed during this survey. | {0 730}                                                         |                                                                                                                          |                          |                                                   |
| {0 800}<br>SS=F                                   | 144G.45 Subd. 2 (a) (4) Fire protection and physical environment<br><br>(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.<br><br>This MN Requirement is not met as evidenced                                                                                                                                                                                                                                                                                                                                                                                                                                               | {0 800}                                                         |                                                                                                                          |                          |                                                   |



Minnesota Department of Health

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                        |                                                                                                                          |  |                                                                    |
|----------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34822</b>              | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>07/22/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HARDING PLACE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>24448 296TH AVENUE<br/>PIERZ, MN 56364</b> |                                                                                                                          |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ID<br>PREFIX<br>TAG                                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                           |
| {0 800}                                                  | Continued From page 10                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | {0 800}                                                                                |                                                                                                                          |  |                                                                    |
|                                                          | by:<br>Not reviewed during this survey.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                        |                                                                                                                          |  |                                                                    |
| {0 810}<br>SS=F                                          | <b>144G.45 Subd. 2 (b-f) Fire protection and physical environment</b><br><br>(b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to:<br>(1) location and number of resident sleeping rooms;<br>(2) staff actions to be taken in the event of a fire or similar emergency;<br>(3) fire protection procedures necessary for residents; and<br>(4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation.<br>(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.<br>(d) Fire safety and evacuation plans shall be readily available at all times within the facility.<br>(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.<br>(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. | {0 810}                                                                                |                                                                                                                          |  |                                                                    |



Minnesota Department of Health

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                        |                                                                                                                          |  |                                                                    |
|----------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34822</b>              | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>07/22/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HARDING PLACE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>24448 296TH AVENUE<br/>PIERZ, MN 56364</b> |                                                                                                                          |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ID<br>PREFIX<br>TAG                                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                           |
| {0 810}                                                  | Continued From page 11                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | {0 810}                                                                                |                                                                                                                          |  |                                                                    |
| {0 830}<br>SS=F                                          | <p>This MN Requirement is not met as evidenced by:<br/>Not reviewed during this survey.</p> <p>144G.45 Subd. 3 Local laws apply</p> <p>Assisted living facilities shall comply with all applicable state and local governing laws, regulations, standards, ordinances, and codes for fire safety, building, and zoning requirements, except a facility with a licensed resident capacity of six or fewer is exempt from rental licensing regulations imposed by any town, municipality, or county.</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on record review and interview, the licensee failed to comply with all applicable state and local regulations. This had the potential to directly affect all residents, staff, and visitors.</p> <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) 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).</p> <p>The findings include:<br/>On July 22, 2025, the surveyor emailed the licensee and requested a plan of correction for the 0830 tag.</p> | {0 830}                                                                                |                                                                                                                          |  |                                                                    |



Minnesota Department of Health

|                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                 |                                                                                                                          |                          |                                                   |
|---------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|---------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>34822 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |                          | (X3) DATE SURVEY COMPLETED<br><br>R<br>07/22/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>HARDING PLACE |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br>24448 296TH AVENUE<br>PIERZ, MN 56364                                           |                          |                                                   |
| (X4) ID<br>PREFIX<br>TAG                          | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ID<br>PREFIX<br>TAG                                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                   |
| {0 830}                                           | <p>Continued From page 12</p> <p>On July 23, 2025, the licensee provided the following documentation:</p> <ul style="list-style-type: none"><li>- an updated correction plan for the 0830 tag, with actions listed from October 30, 2024 to July 23, 2025.</li><li>- A life safety plan set dated June 23, 2025.</li></ul> <p>Previous survey information:</p> <p>On April 24, 2025, the surveyor emailed the licensee and requested a plan of correction for the 0830 tag.</p> <p>On April 25, 2025, the licensee provided the following documentation:</p> <ul style="list-style-type: none"><li>- an undated work order correction form</li><li>- a Minnesota Department of Health assisted living plan submittal form dated March 25, 2025, with a project name "close off a door"</li></ul> <p>Record review of the available documentation indicated a work order for the 0830 tag had been created for replacing a door with a wall. The work order did not include an identified correction order for violations listed in the state fire marshal inspection report dated October 16, 2024. This report listed the building in violation of MSFC 2020-102.4.</p> <p>Record review of the available documentation indicated the plan review application was incomplete. A copy of certified final construction plans were not included with the plan review application. As of May 19, 2025, a completed assisted living plan submittal package had not been received by MDH engineering services.</p> <p>On January 17, 2025, through January 27, 2025,</p> | {0 830}                                                         |                                                                                                                          |                          |                                                   |



Minnesota Department of Health

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                           |                                                                                                                          |  |                                                                    |
|----------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34822</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>07/22/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HARDING PLACE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                           | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>24448 296TH AVENUE<br/>PIERZ, MN 56364</b>                                   |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | ID<br>PREFIX<br>TAG                                                       | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                           |
| {0 830}                                                  | <p>Continued From page 13</p> <p>the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on October 2, 2024.</p> <p>On January 17, 2025, the surveyor emailed the licensee requesting documentation to support that a plan review application had been submitted to Minnesota Department of Health Engineering Services for a new interior wall constructed in front of the apartment door on the upper floor of the facility.</p> <p>On January 17, 2025, the surveyor emailed the licensee requesting documentation to support corrections that had been completed for the violations listed in the state fire marshal inspection report dated October 16, 2024. This report listed the building in violation of MSFC 2020-102.4.</p> <p>On January 27, 2025, the licensee responded that an email was sent to the architect on January 23, 2025, and we are awaiting that report from him.</p> <p>As of February 4, 2025, a plan review application had not been submitted to Minnesota Department of Health Engineering Services.</p> <p>On October 2, 2024, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on July 11, 2024. On October 16, 2024, at 9:00 a.m., survey staff and deputy state fire marshal toured the facility with maintenance personnel (MP)-G, licensed assisted living director in training (LALDT)-H, and licensed assisted living director (LALD)-A. During the tour, the surveyor observed the following:</p> | {0 830}                                                                   |                                                                                                                          |  |                                                                    |



Minnesota Department of Health

|                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                 |                                                                                                                          |                          |                                                   |
|---------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|---------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>34822 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |                          | (X3) DATE SURVEY COMPLETED<br><br>R<br>07/22/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>HARDING PLACE |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br>24448 296TH AVENUE<br>PIERZ, MN 56364                                           |                          |                                                   |
| (X4) ID<br>PREFIX<br>TAG                          | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ID<br>PREFIX<br>TAG                                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                   |
| {0 830}                                           | Continued From page 14<br><br>- A new interior wall had been constructed in front of the apartment door on the upper floor of the facility. During the facility tour interview on October 16, 2024, MP-G verified this wall had been constructed since the previous site visit on September 30, 2024. The licensee failed to submit a plan review application to Minnesota Department of Health engineering services and obtain a permit for installation of this new wall.<br><br>- A state fire marshal fire inspection report dated October 16, 2024, listed the building to be in violation of MSFC 2020-102.4. Conditions were observed that did not meet the minimum requirements of Minnesota State Fire Code. On October 21, 2024, the surveyor was copied on the state fire marshal inspection report that was emailed to the licensee. | {0 830}                                                         |                                                                                                                          |                          |                                                   |
| {0 910}<br>SS=C                                   | 144G.50 Subd. 2 (a-b) Contract information<br><br>(a) The contract must include in a conspicuous place and manner on the contract the legal name and the health facility identification of the facility.<br>(b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of:<br>(1) the facility and contracted service provider when applicable;<br>(2) the licensee of the facility;<br>(3) the managing agent of the facility, if applicable; and<br>(4) the authorized agent for the facility.<br><br>This MN Requirement is not met as evidenced by:<br>Not reviewed during this survey.                                                                                                                                                                   | {0 910}                                                         |                                                                                                                          |                          |                                                   |



Minnesota Department of Health

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                        |                                                                                                                          |  |                                                                    |
|----------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34822</b>              | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>07/22/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HARDING PLACE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>24448 296TH AVENUE<br/>PIERZ, MN 56364</b> |                                                                                                                          |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ID<br>PREFIX<br>TAG                                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                           |
| {0 920}<br>SS=C                                          | <b>144G.50 Subd. 2 (c) Contract information</b><br><br>(c) The contract must include:<br>(1) a disclosure of the category of assisted living facility license held by the facility and, if the facility is not an assisted living facility with dementia care, a disclosure that it does not hold an assisted living facility with dementia care license;<br>(2) a description of all the terms and conditions of the contract, including a description of and any limitations to the housing or assisted living services to be provided for the contracted amount;<br>(3) a delineation of the cost and nature of any other services to be provided for an additional fee;<br>(4) a delineation and description of any additional fees the resident may be required to pay if the resident's condition changes during the term of the contract;<br>(5) a delineation of the grounds under which the resident may be transferred or have housing or services terminated or be subject to an emergency relocation;<br>(6) billing and payment procedures and requirements; and<br>(7) disclosure of the facility's ability to provide specialized diets.<br><br>This MN Requirement is not met as evidenced by:<br>Not reviewed during this survey. | {0 920}                                                                                |                                                                                                                          |  |                                                                    |
| {0 930}<br>SS=C                                          | <b>144G.50 Subd. 2 (d-e; 1-4) Contract information</b><br><br>(d) The contract must include a description of the facility's complaint resolution process available to residents, including the name and contact information of the person representing the facility who is designated to handle and resolve                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | {0 930}                                                                                |                                                                                                                          |  |                                                                    |



Minnesota Department of Health

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                        |                                                                                                                          |  |                                                                    |
|----------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34822</b>              | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>07/22/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HARDING PLACE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>24448 296TH AVENUE<br/>PIERZ, MN 56364</b> |                                                                                                                          |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ID<br>PREFIX<br>TAG                                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                           |
| {0 930}                                                  | Continued From page 16<br><br>complaints.<br>(e) The contract must include a clear and<br>conspicuous notice of:<br>(1) the right under section 144G.54 to appeal the<br>termination of an assisted living contract;<br>(2) the facility's policy regarding transfer of<br>residents within the facility, under what<br>circumstances a transfer may occur, and the<br>circumstances under which resident consent is<br>required for a transfer;<br>(3) contact information for the Office of<br>Ombudsman for Long-Term Care, the<br>Ombudsman for Mental Health and<br>Developmental Disabilities, and the Office of<br>Health Facility Complaints;<br>(4) the resident's right to obtain services from an<br>unaffiliated service provider;<br><br>This MN Requirement is not met as evidenced<br>by:<br>Not reviewed during this survey. | {0 930}                                                                                |                                                                                                                          |  |                                                                    |
| {0 940}<br>SS=C                                          | 144G.50 Subd. 2 (e; 5-7) Contract information<br><br>(5) a description of the facility's policies related to<br>medical assistance waivers under chapter 256S<br>and section 256B.49 and the housing support<br>program under chapter 256I, including:<br>(i) whether the facility is enrolled with the<br>commissioner of human services to provide<br>customized living services under medical<br>assistance waivers;<br>(ii) whether the facility has an agreement to<br>provide housing support under section 256I.04,<br>subdivision 2, paragraph (b);<br>(iii) whether there is a limit on the number of<br>people residing at the facility who can receive<br>customized living services or participate in the<br>housing support program at any point in time. If                                                                    | {0 940}                                                                                |                                                                                                                          |  |                                                                    |



Minnesota Department of Health

|                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                 |                                                                                                                          |                          |                                                   |
|---------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|---------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>34822 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |                          | (X3) DATE SURVEY COMPLETED<br><br>R<br>07/22/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>HARDING PLACE |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br>24448 296TH AVENUE<br>PIERZ, MN 56364                                           |                          |                                                   |
| (X4) ID<br>PREFIX<br>TAG                          | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ID<br>PREFIX<br>TAG                                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                   |
| {0 940}                                           | Continued From page 17<br><br>so, the limit must be provided;<br>(iv) whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required;<br>(v) a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent;<br>(vi) a statement that residents may be eligible for assistance with rent through the housing support program; and<br>(vii) a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program;<br>(6) the contact information to obtain long-term care consulting services under section 256B.0911; and<br>(7) the toll-free phone number for the Minnesota Adult Abuse Reporting Center.<br><br>This MN Requirement is not met as evidenced by:<br>Not reviewed during this survey. | {0 940}                                                         |                                                                                                                          |                          |                                                   |
| {0 950}<br>SS=C                                   | 144G.50 Subd. 3 Designation of representative<br><br>(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:<br><br>"RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES.<br><br>You have the right to name anyone as your                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | {0 950}                                                         |                                                                                                                          |                          |                                                   |



Minnesota Department of Health

|                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                |                                                                                                                          |  |                                                   |
|---------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>34822                | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br>R<br>07/22/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>HARDING PLACE |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | STREET ADDRESS, CITY, STATE, ZIP CODE<br>24448 296TH AVENUE<br>PIERZ, MN 56364 |                                                                                                                          |  |                                                   |
| (X4) ID<br>PREFIX<br>TAG                          | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                          |
| {0 950}                                           | Continued From page 18<br><br>"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."<br><br>(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.<br><br>This MN Requirement is not met as evidenced by:<br>Not reviewed during this survey. | {0 950}                                                                        |                                                                                                                          |  |                                                   |
| {0 970}<br>SS=C                                   | 144G.50 Subd. 5 Waivers of liability prohibited<br><br>The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law.<br><br>This MN Requirement is not met as evidenced by:<br>Not reviewed during this survey.                                                                                                                                                                                                                                                                                                                                                                                             | {0 970}                                                                        |                                                                                                                          |  |                                                   |



Minnesota Department of Health

|                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                 |                                                                                                                          |                          |                                                   |
|---------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|---------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>34822 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |                          | (X3) DATE SURVEY COMPLETED<br><br>R<br>07/22/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>HARDING PLACE |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br>24448 296TH AVENUE<br>PIERZ, MN 56364                                           |                          |                                                   |
| (X4) ID<br>PREFIX<br>TAG                          | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ID<br>PREFIX<br>TAG                                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                   |
| {01500}<br>SS=F                                   | 144G.63 Subd. 5 Required annual training<br><br>(a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include:<br>(1) training on reporting of maltreatment of vulnerable adults under section 626.557;<br>(2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights;<br>(3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases;<br>(4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders;<br>(5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and<br>(6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person.<br>(b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research | {01500}                                                         |                                                                                                                          |                          |                                                   |



Minnesota Department of Health

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                        |                                                                                                                          |  |                                                                 |
|----------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>34822</b>                 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>R</b><br><b>07/22/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HARDING PLACE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>24448 296TH AVENUE<br/>PIERZ, MN 56364</b> |                                                                                                                          |  |                                                                 |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ID<br>PREFIX<br>TAG                                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                        |
| {01500}                                                  | <p>Continued From page 20</p> <p>based, may include online training, and must include training on one or more of the following topics:</p> <p>(1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication;</p> <p>(2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or</p> <p>(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.</p> <p>This MN Requirement is not met as evidenced by:<br/>Not reviewed during this survey.</p> | {01500}                                                                                |                                                                                                                          |  |                                                                 |
| {01530}<br>SS=D                                          | <p><b>144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De-</b></p> <p>(a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements:</p> <p>(1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter;</p>                                                  | {01530}                                                                                |                                                                                                                          |  |                                                                 |



Minnesota Department of Health

|                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                 |                                                                                                                          |                          |                                                   |
|---------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|---------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>34822 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |                          | (X3) DATE SURVEY COMPLETED<br><br>R<br>07/22/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>HARDING PLACE |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br>24448 296TH AVENUE<br>PIERZ, MN 56364                                           |                          |                                                   |
| (X4) ID<br>PREFIX<br>TAG                          | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ID<br>PREFIX<br>TAG                                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                   |
| {01530}                                           | Continued From page 21<br><br>(2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and the initial two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter;<br><br>This MN Requirement is not met as evidenced by:<br>Not reviewed during this survey. | {01530}                                                         |                                                                                                                          |                          |                                                   |
| {01910}<br>SS=D                                   | 144G.71 Subd. 22 Disposition of medications<br><br>(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                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | {01910}                                                         |                                                                                                                          |                          |                                                   |



Minnesota Department of Health

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                        |                                                                                                                          |  |                                                                    |
|----------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34822</b>              | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>07/22/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HARDING PLACE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>24448 296TH AVENUE<br/>PIERZ, MN 56364</b> |                                                                                                                          |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ID<br>PREFIX<br>TAG                                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                           |
| {01910}                                                  | Continued From page 22<br><br>disposal.<br>(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 medications and controlled substances.<br>(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.<br><br>This MN Requirement is not met as evidenced by:<br>Not reviewed during this survey. | {01910}                                                                                |                                                                                                                          |  |                                                                    |
| {02320}<br>SS=D                                          | 144G.91 Subd. 4 (b) Appropriate care and services<br><br>(b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan.<br><br>This MN Requirement is not met as evidenced by:<br>Not reviewed during this survey.                                                                                                                                                                                                                                                                                                      | {02320}                                                                                |                                                                                                                          |  |                                                                    |
| {02420}<br>SS=F                                          | 144G.91 Subd. 14 Communication privacy<br><br>(a) Residents have the right to communicate privately with persons of their choice.<br>(b) If an assisted living facility is sending or                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | {02420}                                                                                |                                                                                                                          |  |                                                                    |



Minnesota Department of Health

|                                                          |                                                                                                                                                                                                                                                                                                                           |                                                                                        |                                                                                                                          |  |                                                                    |
|----------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION      |                                                                                                                                                                                                                                                                                                                           | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34822</b>              | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>07/22/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HARDING PLACE</b> |                                                                                                                                                                                                                                                                                                                           | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>24448 296TH AVENUE<br/>PIERZ, MN 56364</b> |                                                                                                                          |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                              | ID<br>PREFIX<br>TAG                                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                           |
| {02420}                                                  | <p>Continued From page 23</p> <p>receiving mail on behalf of residents, the assisted living facility must do so without interference.<br/>(c) Residents must be provided access to a telephone to make and receive calls.</p> <p>This MN Requirement is not met as evidenced by:<br/>Not reviewed during this survey.</p> | {02420}                                                                                |                                                                                                                          |  |                                                                    |





*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically Delivered

June 9, 2025

Licensee  
Harding Place  
24448 296th Avenue  
Pierz, MN 56364

RE: Project Number(s) SL34822015

Dear Licensee:

On April 23, 2025, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on July 11, 2024. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the July 11, 2024 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on July 11, 2024, found not corrected at the time of the April 23, 2025, follow-up survey and/or subject to penalty assessment are as follows:

**0830-Local Laws Apply-144g.45 Subd. 3 - \$500.00**

The details of the violations noted at the time of this follow-up survey completed on April 23, 2025 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

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

**DOCUMENTATION OF ACTION TO COMPLY**

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

**IMPOSITION OF FINES:**

Level 1: no fines or enforcement.

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

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

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



§144G.20.

**CORRECTION ORDER RECONSIDERATION PROCESS**

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

To submit a reconsideration request, please visit:

**<https://forms.web.health.state.mn.us/form/HRDAppealsForm>**

**REQUESTING A HEARING**

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

To submit a hearing request, please visit:

**<https://forms.web.health.state.mn.us/form/HRDAppealsForm>**

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

We urge you to review these orders carefully. If you have questions, please contact Benjamin J. Zwart at 651-201-3715.

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

Sincerely,



Benjamin J. Zwart, P.E., Supervisor  
State Engineering Services Section  
Health Regulation Division  
Email: Benjamin.Zwart@state.mn.us  
Telephone: 651-201-3715 Fax: 1-866-890-9290

HHH



Minnesota Department of Health

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                        |                                                                                                                          |  |                                                                    |
|----------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34822</b>              | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>04/23/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HARDING PLACE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>24448 296TH AVENUE<br/>PIERZ, MN 56364</b> |                                                                                                                          |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ID<br>PREFIX<br>TAG                                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                           |
| {0 000}                                                  | <p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>ASSISTED LIVING PROVIDER LICENSING<br/>CORRECTION ORDER</p> <p>In accordance with Minnesota Statutes, section<br/>144G.08 to 144G.95 this correction order(s) has<br/>been issued pursuant to a survey.</p> <p>Determination of whether a violation has been<br/>corrected requires compliance with all<br/>requirements provided at the Statute number<br/>indicated below. When Minnesota Statute<br/>contains several items, failure to comply with any<br/>of the items will be considered lack of<br/>compliance.</p> <p>INITIAL COMMENTS:</p> <p>SL#34822015-3</p> <p>On April 24, 2025, through April 25, 2025, the<br/>Minnesota Department of Health conducted a<br/>follow-up survey at the above provider to<br/>follow-up on orders issued pursuant to a survey<br/>completed on January 27, 2025. At the time of<br/>the survey, there were eighteen (18) residents all<br/>of whom received services under the Assisted<br/>Living license. As a result of the follow-up survey,<br/>the following orders were reissued.</p> | {0 000}                                                                                |                                                                                                                          |  |                                                                    |
| {0 100}<br>SS=F                                          | <p>144G.10 Subdivision 1 License required</p> <p>(a)(1)Beginning August 1, 2021, no assisted living<br/>facility may operate in Minnesota unless it is<br/>licensed under this chapter.</p> <p>(2) No facility or building on a campus may<br/>provide assisted living services until obtaining the</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | {0 100}                                                                                |                                                                                                                          |  |                                                                    |

Minnesota Department of Health

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

TITLE

(X6) DATE



Minnesota Department of Health

|                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                |                                                                                                                          |  |                                                   |
|---------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>34822                | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br>R<br>04/23/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>HARDING PLACE |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br>24448 296TH AVENUE<br>PIERZ, MN 56364 |                                                                                                                          |  |                                                   |
| (X4) ID<br>PREFIX<br>TAG                          | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                          |
| {0 100}                                           | Continued From page 1<br><br>required license under paragraphs (c) to (e).<br>(b)The licensee is legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. Nothing in this chapter shall in any way affect the rights and remedies available under other law.<br>(c) Upon approving an application for an assisted living facility license, the commissioner shall issue a single license for each building that is operated by the licensee as an assisted living facility and is located at a separate address, except as provided under paragraph (d) or (e).<br>(d) Upon approving an application for an assisted living facility license, the commissioner may issue a single license for two or more buildings on a campus that are operated by the same licensee as an assisted living facility. An assisted living facility license for a campus must identify the address and licensed resident capacity of each building located on the campus in which assisted living services are provided.<br>(e) Upon approving an application for an assisted living facility license, the commissioner may:<br>(1) issue a single license for two or more buildings on a campus that are operated by the same licensee as an assisted living facility with dementia care, provided the assisted living facility for dementia care license for a campus identifies the buildings operating as assisted living facilities with dementia care; or<br>(2) issue a separate assisted living facility with dementia care license for a building that is on a campus and that is operating as an assisted living facility with dementia care.<br><br>This MN Requirement is not met as evidenced by:<br>Not reviewed during this survey. | {0 100}                                                                        |                                                                                                                          |  |                                                   |



Minnesota Department of Health

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                           |                                                                                                                          |  |                                                                    |
|----------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34822</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>04/23/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HARDING PLACE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                           | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>24448 296TH AVENUE<br/>PIERZ, MN 56364</b>                                   |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ID<br>PREFIX<br>TAG                                                       | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                           |
| {0 100}                                                  | Continued From page 2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | {0 100}                                                                   |                                                                                                                          |  |                                                                    |
| {0 460}<br>SS=F                                          | <b>144G.41 Subdivision 1 Minimum requirements</b><br><br>(5) provide a means for residents to request assistance for health and safety needs 24 hours per day, seven days per week;<br>(6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract;<br>(7) permit residents access to food at any time;<br>(8) allow residents to choose the resident's visitors and times of visits;<br>(9) allow the resident the right to choose a roommate if sharing a unit;<br>(10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living facility must not lock a resident in the resident's unit;<br><br>This MN Requirement is not met as evidenced by:<br>Not reviewed during this survey. | {0 460}                                                                   |                                                                                                                          |  |                                                                    |
| {0 470}<br>SS=F                                          | <b>144G.41 Subdivision 1 Minimum requirements</b><br><br>(11) develop and implement a staffing plan for determining its staffing level that:<br>(i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility;<br>(ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | {0 470}                                                                   |                                                                                                                          |  |                                                                    |



Minnesota Department of Health

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                        |                                                                                                                          |  |                                                                    |
|----------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34822</b>              | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>04/23/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HARDING PLACE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>24448 296TH AVENUE<br/>PIERZ, MN 56364</b> |                                                                                                                          |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ID<br>PREFIX<br>TAG                                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                           |
| {0 470}                                                  | Continued From page 3<br><br>on a 24-hour per day basis; and<br>(iii) ensures that the facility can respond promptly<br>and effectively to individual resident emergencies<br>and to emergency, life safety, and disaster<br>situations affecting staff or residents in the facility;<br>(12) ensure that one or more persons are<br>available 24 hours per day, seven days per week,<br>who are responsible for responding to the<br>requests of residents for assistance with health or<br>safety needs. Such persons must be:<br>(i) awake;<br>(ii) located in the same building, in an attached<br>building, or on a contiguous campus with the<br>facility in order to respond within a reasonable<br>amount of time;<br>(iii) capable of communicating with residents;<br>(iv) capable of providing or summoning the<br>appropriate assistance; and<br>(v) capable of following directions;<br><br>This MN Requirement is not met as evidenced<br>by:<br>Not reviewed during this survey. | {0 470}                                                                                |                                                                                                                          |  |                                                                    |
| {0 480}<br>SS=F                                          | 144G.41 Subdivision 1 Subd. 1a (a-b) Minimum<br>requirements; required food services<br><br>(a) Except as provided in paragraph (b), food<br>must be prepared and served according to the<br>Minnesota Food Code, Minnesota Rules, chapter<br>4626.<br>(b) For an assisted living facility with a licensed<br>capacity of ten or fewer residents:<br>(1) notwithstanding Minnesota Rules, part<br>4626.0033, item A, the facility may share a<br>certified food protection manager (CFPM) with<br>one other facility located within a 60-mile radius<br>and under common management provided the<br>CFPM is present at each facility frequently                                                                                                                                                                                                                                                                                                                                                 | {0 480}                                                                                |                                                                                                                          |  |                                                                    |



Minnesota Department of Health

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                        |                                                                                                                          |  |                                                                    |
|----------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34822</b>              | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>04/23/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HARDING PLACE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>24448 296TH AVENUE<br/>PIERZ, MN 56364</b> |                                                                                                                          |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ID<br>PREFIX<br>TAG                                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                           |
| {0 480}                                                  | <p>Continued From page 4</p> <p>enough to effectively administer, manage, and supervise each facility's food service operation;</p> <p>(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;</p> <p>(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;</p> <p>(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;</p> <p>(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;</p> <p>(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</p> <p>(7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door.</p> | {0 480}                                                                                |                                                                                                                          |  |                                                                    |



Minnesota Department of Health

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                        |                                                                                                                          |  |                                                                    |
|----------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34822</b>              | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>04/23/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HARDING PLACE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>24448 296TH AVENUE<br/>PIERZ, MN 56364</b> |                                                                                                                          |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ID<br>PREFIX<br>TAG                                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                           |
| {0 480}                                                  | Continued From page 5<br><br>This MN Requirement is not met as evidenced<br>by:<br>Not reviewed during this survey.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | {0 480}                                                                                |                                                                                                                          |  |                                                                    |
| {0 640}<br>SS=F                                          | 144G.42 Subd. 7 Posting information for<br>reporting suspected c<br><br>The facility shall support protection and safety<br>through access to the state's systems for<br>reporting suspected criminal activity and<br>suspected vulnerable adult maltreatment by:<br>(1) posting the 911 emergency number in<br>common areas and near telephones provided by<br>the assisted living facility;<br>(2) posting information and the reporting number<br>for the Minnesota Adult Abuse Reporting Center<br>to report suspected maltreatment of a vulnerable<br>adult under section 626.557; and<br>(3) providing reasonable accommodations with<br>information and notices in plain language.<br><br>This MN Requirement is not met as evidenced<br>by:<br>Not reviewed during this survey. | {0 640}                                                                                |                                                                                                                          |  |                                                                    |
| {0 650}<br>SS=F                                          | 144G.42 Subd. 8 (a) Staff records<br><br>(a) The facility must maintain current records of<br>each paid staff member, each regularly<br>scheduled volunteer providing services, and each<br>individual contractor providing services. The<br>records must include the following infomation:<br>(1) evidence of current professional licensure,<br>registration, or certification if licensure,<br>registration, or certification is required by this<br>chapter or rules;<br>(2) records of orientation, required annual training<br>and infection control training, and competency                                                                                                                                                                                                     | {0 650}                                                                                |                                                                                                                          |  |                                                                    |



Minnesota Department of Health

|                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                 |                                                                                                                          |  |                                                   |
|---------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>34822 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br>R<br>04/23/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>HARDING PLACE |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br>24448 296TH AVENUE<br>PIERZ, MN 56364                                           |  |                                                   |
| (X4) ID<br>PREFIX<br>TAG                          | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ID<br>PREFIX<br>TAG                                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                          |
| {0 650}                                           | Continued From page 6<br><br>evaluations;<br>(3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision;<br>(4) documentation of annual performance reviews that identify areas of improvement needed and training needs;<br>(5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and<br>(6) documentation of the background study as required under section 144.057.<br><br>This MN Requirement is not met as evidenced by:<br>Not reviewed during this survey.                                                                                                                                                                            | {0 650}                                                         |                                                                                                                          |  |                                                   |
| {0 660}<br>SS=F                                   | 144G.42 Subd. 9 Tuberculosis prevention and control<br><br>(a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines.<br>(b) The facility must maintain written evidence of compliance with this subdivision.<br><br>This MN Requirement is not met as evidenced | {0 660}                                                         |                                                                                                                          |  |                                                   |



Minnesota Department of Health

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                        |                                                                                                                          |  |                                                                    |
|----------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34822</b>              | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>04/23/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HARDING PLACE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>24448 296TH AVENUE<br/>PIERZ, MN 56364</b> |                                                                                                                          |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ID<br>PREFIX<br>TAG                                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                           |
| {0 660}                                                  | Continued From page 7<br><br>by:<br>Not reviewed during this survey.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | {0 660}                                                                                |                                                                                                                          |  |                                                                    |
| {0 680}<br>SS=F                                          | <b>144G.42 Subd. 10 Disaster planning and<br/>emergency preparedness</b><br><br>(a) The facility must meet the following<br>requirements:<br>(1) have a written emergency disaster plan that<br>contains a plan for evacuation, addresses<br>elements of sheltering in place, identifies<br>temporary relocation sites, and details staff<br>assignments in the event of a disaster or an<br>emergency;<br>(2) post an emergency disaster plan prominently;<br>(3) provide building emergency exit diagrams to<br>all residents;<br>(4) post emergency exit diagrams on each floor;<br>and<br>(5) have a written policy and procedure regarding<br>missing residents.<br>(b) The facility must provide emergency and<br>disaster training to all staff during the initial staff<br>orientation and annually thereafter and must<br>make emergency and disaster training annually<br>available to all residents. Staff who have not<br>received emergency and disaster training are<br>allowed to work only when trained staff are also<br>working on site.<br>(c) The facility must meet any additional<br>requirements adopted in rule.<br><br>This MN Requirement is not met as evidenced<br>by:<br>Not reviewed during this survey. | {0 680}                                                                                |                                                                                                                          |  |                                                                    |
| {0 730}<br>SS=F                                          | <b>144G.43 Subd. 3 Contents of resident record</b><br><br>Contents of a resident record include the                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | {0 730}                                                                                |                                                                                                                          |  |                                                                    |



Minnesota Department of Health

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                        |                                                                                                                          |  |                                                                    |
|----------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34822</b>              | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>04/23/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HARDING PLACE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>24448 296TH AVENUE<br/>PIERZ, MN 56364</b> |                                                                                                                          |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ID<br>PREFIX<br>TAG                                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                           |
| {0 730}                                                  | <p>Continued From page 8</p> <p>following for each resident:</p> <p>(1) identifying information, including the resident's name, date of birth, address, and telephone number;</p> <p>(2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative;</p> <p>(3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known;</p> <p>(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;</p> <p>(5) the resident's advance directives, if any;</p> <p>(6) copies of any health care directives, guardianships, powers of attorney, or conservatorships;</p> <p>(7) the facility's current and previous assessments and service plans;</p> <p>(8) all records of communications pertinent to the resident's services;</p> <p>(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;</p> <p>(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;</p> <p>(11) documentation that services have been provided as identified in the service plan;</p> <p>(12) documentation that the resident has received and reviewed the assisted living bill of rights;</p> <p>(13) documentation of complaints received and any resolution;</p> | {0 730}                                                                                |                                                                                                                          |  |                                                                    |



Minnesota Department of Health

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                        |                                                                                                                          |  |                                                                    |
|----------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34822</b>              | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>04/23/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HARDING PLACE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>24448 296TH AVENUE<br/>PIERZ, MN 56364</b> |                                                                                                                          |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                         | ID<br>PREFIX<br>TAG                                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                           |
| {0 730}                                                  | Continued From page 9<br><br>(14) a discharge summary, including service<br>termination notice and related documentation,<br>when applicable; and<br>(15) other documentation required under this<br>chapter and relevant to the resident's services or<br>status.<br><br>This MN Requirement is not met as evidenced<br>by:<br>Not reviewed during this survey.                                                                                                                                     | {0 730}                                                                                |                                                                                                                          |  |                                                                    |
| {0 800}<br>SS=F                                          | 144G.45 Subd. 2 (a) (4) Fire protection and<br>physical environment<br><br>(4) keep the physical environment, including<br>walls, floors, ceiling, all furnishings, grounds,<br>systems, and equipment in a continuous state of<br>good repair and operation with regard to the<br>health, safety, comfort, and well-being of the<br>residents in accordance with a maintenance and<br>repair program.<br><br>This MN Requirement is not met as evidenced<br>by:<br>Not reviewed during this survey. | {0 800}                                                                                |                                                                                                                          |  |                                                                    |
| {0 810}<br>SS=F                                          | 144G.45 Subd. 2 (b-f) Fire protection and<br>physical environment<br><br>(b) Each assisted living facility shall develop and<br>maintain fire safety and evacuation plans. The<br>plans shall include but are not limited to:<br>(1) location and number of resident sleeping<br>rooms;<br>(2) staff actions to be taken in the event of a fire<br>or similar emergency;<br>(3) fire protection procedures necessary for                                                                             | {0 810}                                                                                |                                                                                                                          |  |                                                                    |



Minnesota Department of Health  
STATE FORM 6899 42|Z14 If continuation sheet 11 of 23



Minnesota Department of Health

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                        |                                                                                                                          |  |                                                                    |
|----------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34822</b>              | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>04/23/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HARDING PLACE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>24448 296TH AVENUE<br/>PIERZ, MN 56364</b> |                                                                                                                          |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ID<br>PREFIX<br>TAG                                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                           |
| {0 830}                                                  | <p>Continued From page 11</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on record review and interview, the licensee failed to comply with all applicable state and local regulations. This had the potential to directly affect all residents, staff, and visitors.</p> <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) 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).</p> <p>The findings include:</p> <p>On April 24, 2025, the surveyor emailed the licensee and requested a plan of correction for the 0830 tag.</p> <p>On April 25, 2025, the licensee provided the following documentation:<br/>- an undated work order correction form<br/>- a Minnesota Department of Health assisted living plan submittal form dated March 25, 2025, with a project name "close off a door"</p> <p>Record review of the available documentation indicated a work order for the 0830 tag had been created for replacing a door with a wall. The work order did not include an identified correction order for violations listed in the state fire marshal inspection report dated October 16, 2024. This report listed the building in violation of MSFC 2020-102.4.</p> | {0 830}                                                                                |                                                                                                                          |  |                                                                    |



Minnesota Department of Health

|                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                 |                                                                                                                          |  |                                                   |
|---------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>34822 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br>R<br>04/23/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>HARDING PLACE |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br>24448 296TH AVENUE<br>PIERZ, MN 56364                                           |  |                                                   |
| (X4) ID<br>PREFIX<br>TAG                          | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ID<br>PREFIX<br>TAG                                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                          |
| {0 830}                                           | <p>Continued From page 12</p> <p>Record review of the available documentation indicated the plan review application was incomplete. A copy of certified final construction plans were not included with the plan review application. As of May 19, 2025, a completed assisted living plan submittal package had not been received by MDH engineering services.</p> <p>Previous survey information:</p> <p>On January 17, 2025, through January 27, 2025, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on October 2, 2024.</p> <p>On January 17, 2025, the surveyor emailed the licensee requesting documentation to support that a plan review application had been submitted to Minnesota Department of Health Engineering Services for a new interior wall constructed in front of the apartment door on the upper floor of the facility.</p> <p>On January 17, 2025, the surveyor emailed the licensee requesting documentation to support corrections that had been completed for the violations listed in the state fire marshal inspection report dated October 16, 2024. This report listed the building in violation of MSFC 2020-102.4.</p> <p>On January 27, 2025, the licensee responded that an email was sent to the architect on January 23, 2025, and we are awaiting that report from him.</p> <p>As of February 4, 2025, a plan review application had not been submitted to Minnesota Department</p> | {0 830}                                                         |                                                                                                                          |  |                                                   |



Minnesota Department of Health

|                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                |                                                                                                                 |  |                                                   |
|---------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>34822                | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                           |  | (X3) DATE SURVEY COMPLETED<br><br>R<br>04/23/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>HARDING PLACE |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | STREET ADDRESS, CITY, STATE, ZIP CODE<br>24448 296TH AVENUE<br>PIERZ, MN 56364 |                                                                                                                 |  |                                                   |
| (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                                |
| {0 830}                                           | Continued From page 13<br><br>of Health Engineering Services.<br><br>On October 2, 2024, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on July 11, 2024. On October 16, 2024, at 9:00 a.m., survey staff and deputy state fire marshal toured the facility with maintenance personnel (MP)-G, licensed assisted living director in training (LALDT)-H, and licensed assisted living director (LALD)-A. During the tour, the surveyor observed the following:<br><br>- A new interior wall had been constructed in front of the apartment door on the upper floor of the facility. During the facility tour interview on October 16, 2024, MP-G verified this wall had been constructed since the previous site visit on September 30, 2024. The licensee failed to submit a plan review application to Minnesota Department of Health engineering services and obtain a permit for installation of this new wall.<br><br>- A state fire marshal fire inspection report dated October 16, 2024, listed the building to be in violation of MSFC 2020-102.4. Conditions were observed that did not meet the minimum requirements of Minnesota State Fire Code. On October 21, 2024, the surveyor was copied on the state fire marshal inspection report that was emailed to the licensee. | {0 830}                                                                        |                                                                                                                 |  |                                                   |
| {0 910}<br>SS=C                                   | 144G.50 Subd. 2 (a-b) Contract information<br><br>(a) The contract must include in a conspicuous place and manner on the contract the legal name and the health facility identification of the facility.<br>(b) The contract must include the name, telephone number, and physical mailing address,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | {0 910}                                                                        |                                                                                                                 |  |                                                   |



Minnesota Department of Health

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                        |                                                                                                                          |  |                                                                    |
|----------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34822</b>              | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>04/23/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HARDING PLACE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>24448 296TH AVENUE<br/>PIERZ, MN 56364</b> |                                                                                                                          |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | ID<br>PREFIX<br>TAG                                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                           |
| {0 910}                                                  | Continued From page 14<br><br>which may not be a public or private post office<br>box, of:<br>(1) the facility and contracted service provider<br>when applicable;<br>(2) the licensee of the facility;<br>(3) the managing agent of the facility, if<br>applicable; and<br>(4) the authorized agent for the facility.<br><br>This MN Requirement is not met as evidenced<br>by:<br>Not reviewed during this survey.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | {0 910}                                                                                |                                                                                                                          |  |                                                                    |
| {0 920}<br>SS=C                                          | 144G.50 Subd. 2 (c) Contract information<br><br>(c) The contract must include:<br>(1) a disclosure of the category of assisted living<br>facility license held by the facility and, if the facility<br>is not an assisted living facility with dementia<br>care, a disclosure that it does not hold an<br>assisted living facility with dementia care license;<br>(2) a description of all the terms and conditions of<br>the contract, including a description of and any<br>limitations to the housing or assisted living<br>services to be provided for the contracted<br>amount;<br>(3) a delineation of the cost and nature of any<br>other services to be provided for an additional<br>fee;<br>(4) a delineation and description of any additional<br>fees the resident may be required to pay if the<br>resident's condition changes during the term of<br>the contract;<br>(5) a delineation of the grounds under which the<br>resident may be transferred or have housing or<br>services terminated or be subject to an<br>emergency relocation;<br>(6) billing and payment procedures and<br>requirements; and | {0 920}                                                                                |                                                                                                                          |  |                                                                    |



Minnesota Department of Health

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                           |                                                                                                                          |  |                                                                    |
|----------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34822</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>04/23/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HARDING PLACE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                           | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>24448 296TH AVENUE<br/>PIERZ, MN 56364</b>                                   |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ID<br>PREFIX<br>TAG                                                       | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                           |
| {0 920}                                                  | Continued From page 15<br><br>(7) disclosure of the facility's ability to provide<br>specialized diets.<br><br>This MN Requirement is not met as evidenced<br>by:<br>Not reviewed during this survey.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | {0 920}                                                                   |                                                                                                                          |  |                                                                    |
| {0 930}<br>SS=C                                          | 144G.50 Subd. 2 (d-e; 1-4) Contract information<br><br>(d) The contract must include a description of the<br>facility's complaint resolution process available to<br>residents, including the name and contact<br>information of the person representing the facility<br>who is designated to handle and resolve<br>complaints.<br>(e) The contract must include a clear and<br>conspicuous notice of:<br>(1) the right under section 144G.54 to appeal the<br>termination of an assisted living contract;<br>(2) the facility's policy regarding transfer of<br>residents within the facility, under what<br>circumstances a transfer may occur, and the<br>circumstances under which resident consent is<br>required for a transfer;<br>(3) contact information for the Office of<br>Ombudsman for Long-Term Care, the<br>Ombudsman for Mental Health and<br>Developmental Disabilities, and the Office of<br>Health Facility Complaints;<br>(4) the resident's right to obtain services from an<br>unaffiliated service provider;<br><br>This MN Requirement is not met as evidenced<br>by:<br>Not reviewed during this survey. | {0 930}                                                                   |                                                                                                                          |  |                                                                    |
| {0 940}<br>SS=C                                          | 144G.50 Subd. 2 (e; 5-7) Contract information<br><br>(5) a description of the facility's policies related to                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | {0 940}                                                                   |                                                                                                                          |  |                                                                    |



Minnesota Department of Health

|                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                |                                                                                                                          |  |                                                   |
|---------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>34822                | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br>R<br>04/23/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>HARDING PLACE |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br>24448 296TH AVENUE<br>PIERZ, MN 56364 |                                                                                                                          |  |                                                   |
| (X4) ID<br>PREFIX<br>TAG                          | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                          |
| {0 940}                                           | <p>Continued From page 16</p> <p>medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including:</p> <p>(i) whether the facility is enrolled with the commissioner of human services to provide customized living services under medical assistance waivers;</p> <p>(ii) whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b);</p> <p>(iii) whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided;</p> <p>(iv) whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required;</p> <p>(v) a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent;</p> <p>(vi) a statement that residents may be eligible for assistance with rent through the housing support program; and</p> <p>(vii) a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program;</p> <p>(6) the contact information to obtain long-term care consulting services under section 256B.0911; and</p> <p>(7) the toll-free phone number for the Minnesota Adult Abuse Reporting Center.</p> <p>This MN Requirement is not met as evidenced by:<br/>Not reviewed during this survey.</p> | {0 940}                                                                        |                                                                                                                          |  |                                                   |



Minnesota Department of Health

|                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                |                                                                                                                          |  |                                                   |
|---------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>34822                | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br>R<br>04/23/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>HARDING PLACE |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | STREET ADDRESS, CITY, STATE, ZIP CODE<br>24448 296TH AVENUE<br>PIERZ, MN 56364 |                                                                                                                          |  |                                                   |
| (X4) ID<br>PREFIX<br>TAG                          | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                          |
| {0 950}<br>SS=C                                   | 144G.50 Subd. 3 Designation of representative<br><br>(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:<br><br>"RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES.<br><br>You have the right to name anyone as your "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."<br><br>(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.<br><br>This MN Requirement is not met as evidenced by:<br>Not reviewed during this survey. | {0 950}                                                                        |                                                                                                                          |  |                                                   |
| {0 970}<br>SS=C                                   | 144G.50 Subd. 5 Waivers of liability prohibited<br><br>The contract must not include a waiver of facility liability for the health and safety or personal                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | {0 970}                                                                        |                                                                                                                          |  |                                                   |



Minnesota Department of Health

|                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                |                                                                                                                          |  |                                                   |
|---------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>34822                | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br>R<br>04/23/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>HARDING PLACE |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>24448 296TH AVENUE<br>PIERZ, MN 56364 |                                                                                                                          |  |                                                   |
| (X4) ID<br>PREFIX<br>TAG                          | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                          |
| {0 970}                                           | Continued From page 18<br><br>property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law.<br><br>This MN Requirement is not met as evidenced by:<br>Not reviewed during this survey.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | {0 970}                                                                        |                                                                                                                          |  |                                                   |
| {01500}<br>SS=F                                   | 144G.63 Subd. 5 Required annual training<br><br>(a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include:<br>(1) training on reporting of maltreatment of vulnerable adults under section 626.557;<br>(2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights;<br>(3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases;<br>(4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with | {01500}                                                                        |                                                                                                                          |  |                                                   |



Minnesota Department of Health

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                        |                                                                                                                          |  |                                                                 |
|----------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>34822</b>                 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>R</b><br><b>04/23/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HARDING PLACE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>24448 296TH AVENUE<br/>PIERZ, MN 56364</b> |                                                                                                                          |  |                                                                 |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ID<br>PREFIX<br>TAG                                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                        |
| {01500}                                                  | Continued From page 19<br><br>residents who have dementia, Alzheimer's disease, or related disorders;<br>(5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and<br>(6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person.<br>(b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics:<br>(1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication;<br>(2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or<br>(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.<br><br>This MN Requirement is not met as evidenced by:<br>Not reviewed during this survey. | {01500}                                                                                |                                                                                                                          |  |                                                                 |
| {01530}<br>SS=D                                          | 144G.64 TRAINING IN DEMENTIA CARE<br>REQUIRED<br><br>(a) All assisted living facilities must meet the                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | {01530}                                                                                |                                                                                                                          |  |                                                                 |



Minnesota Department of Health

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                           |                                                                                                                          |  |                                                                    |
|----------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34822</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>04/23/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HARDING PLACE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                           | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>24448 296TH AVENUE<br/>PIERZ, MN 56364</b>                                   |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ID<br>PREFIX<br>TAG                                                       | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                           |
| {01530}                                                  | Continued From page 20<br><br>following training requirements:<br>(1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter;<br>(2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter;<br><br>This MN Requirement is not met as evidenced by:<br>Not reviewed during this survey. | {01530}                                                                   |                                                                                                                          |  |                                                                    |
| {01910}<br>SS=D                                          | 144G.71 Subd. 22 Disposition of medications<br><br>(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                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | {01910}                                                                   |                                                                                                                          |  |                                                                    |



Minnesota Department of Health

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                        |                                                                                                                          |  |                                                                 |
|----------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>34822</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>R</b><br><b>04/23/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HARDING PLACE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>24448 296TH AVENUE<br/>PIERZ, MN 56364</b>                                   |  |                                                                 |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                        |
| {01910}                                                  | Continued From page 21<br><br>disposal.<br>(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 medications and controlled substances.<br>(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.<br><br>This MN Requirement is not met as evidenced by:<br>Not reviewed during this survey. | {01910}                                                                |                                                                                                                          |  |                                                                 |
| {02320}<br>SS=D                                          | 144G.91 Subd. 4 (b) Appropriate care and services<br><br>(b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan.<br><br>This MN Requirement is not met as evidenced by:<br>Not reviewed during this survey.                                                                                                                                                                                                                                                                                                      | {02320}                                                                |                                                                                                                          |  |                                                                 |
| {02420}<br>SS=F                                          | 144G.91 Subd. 14 Communication privacy<br><br>(a) Residents have the right to communicate privately with persons of their choice.<br>(b) If an assisted living facility is sending or                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | {02420}                                                                |                                                                                                                          |  |                                                                 |



Minnesota Department of Health

|                                                          |                                                                                                                                                                                                                                                                                                                           |                                                                           |                                                                                                                          |                          |                                                                    |
|----------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION      |                                                                                                                                                                                                                                                                                                                           | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34822</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>04/23/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HARDING PLACE</b> |                                                                                                                                                                                                                                                                                                                           |                                                                           | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>24448 296TH AVENUE<br/>PIERZ, MN 56364</b>                                   |                          |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                              | ID<br>PREFIX<br>TAG                                                       | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                                    |
| {02420}                                                  | <p>Continued From page 22</p> <p>receiving mail on behalf of residents, the assisted living facility must do so without interference.<br/>(c) Residents must be provided access to a telephone to make and receive calls.</p> <p>This MN Requirement is not met as evidenced by:<br/>Not reviewed during this survey.</p> | {02420}                                                                   |                                                                                                                          |                          |                                                                    |





*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically Delivered

March 3, 2025

Licensee  
Harding Place  
24448 296th Avenue  
Pierz, MN 56364

RE: Project Number(s) SL34822015

Dear Licensee:

On January 17, 2025, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on July 11, 2024. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the July 11, 2024 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on July 11, 2024, found not corrected at the time of the January 17, 2025, follow-up survey and/or subject to penalty assessment are as follows:

**0780-Fire Protection And Physical Environment-144g.45 Subd. 2 (a) (1) - \$500.00**  
**0830-Local Laws Apply-144g.45 Subd. 3 - \$500.00**

The details of the violations noted at the time of this follow-up survey completed on January 17, 2025 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$1,000.00**. 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 outlined on the state form; however, plans of correction are not required to be submitted for approval.

#### **IMPOSITION OF FINES:**

Level 1: no fines or enforcement.

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

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



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

### **CORRECTION ORDER RECONSIDERATION PROCESS**

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

To submit a reconsideration request, please visit:

**<https://forms.web.health.state.mn.us/form/HRDAppealsForm>**

### **REQUESTING A HEARING**

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

To submit a hearing request, please visit:

**<https://forms.web.health.state.mn.us/form/HRDAppealsForm>**

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

We urge you to review these orders carefully. If you have questions, please contact Benjamin J. Zwart at 651-201-3715.

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

Sincerely,



Benjamin J. Zwart, Supervisor  
State Engineering Services Section  
Email: Benjamin.Zwart@state.mn.us  
Telephone: 651-201-3715 Fax: 1-866-890-9290

HHH



Minnesota Department of Health

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                        |                                                                                                                          |  |                                                                    |
|----------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34822</b>              | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>01/17/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HARDING PLACE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>24448 296TH AVENUE<br/>PIERZ, MN 56364</b> |                                                                                                                          |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ID<br>PREFIX<br>TAG                                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                           |
| {0 000}                                                  | <p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>ASSISTED LIVING PROVIDER LICENSING<br/>CORRECTION ORDER</p> <p>In accordance with Minnesota Statutes, section<br/>144G.08 to 144G.95 this correction order(s) has<br/>been issued pursuant to a survey.</p> <p>Determination of whether a violation has been<br/>corrected requires compliance with all<br/>requirements provided at the Statute number<br/>indicated below. When Minnesota Statute<br/>contains several items, failure to comply with any<br/>of the items will be considered lack of<br/>compliance.</p> <p>INITIAL COMMENTS:</p> <p>SL#34822015-2</p> <p>On January 17, 2025, through January 27, 2025,<br/>the Minnesota Department of Health conducted a<br/>follow-up survey at the above provider to<br/>follow-up on orders issued pursuant to a survey<br/>completed on October 2, 2024. At the time of the<br/>survey, there were eighteen (18) residents all of<br/>whom received services under the Assisted Living<br/>license. As a result of the follow-up survey, the<br/>following orders were reissued.</p> | {0 000}                                                                                |                                                                                                                          |  |                                                                    |
| {0 100}<br>SS=F                                          | <p>144G.10 Subdivision 1 License required</p> <p>(a)(1)Beginning August 1, 2021, no assisted living<br/>facility may operate in Minnesota unless it is<br/>licensed under this chapter.</p> <p>(2) No facility or building on a campus may<br/>provide assisted living services until obtaining the</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | {0 100}                                                                                |                                                                                                                          |  |                                                                    |

Minnesota Department of Health

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

TITLE

(X6) DATE



Minnesota Department of Health

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                        |                                                                                                                          |  |                                                                 |
|----------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>34822</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>R</b><br><b>01/17/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HARDING PLACE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>24448 296TH AVENUE<br/>PIERZ, MN 56364</b>                                   |  |                                                                 |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                        |
| {0 100}                                                  | <p>Continued From page 1</p> <p>required license under paragraphs (c) to (e).<br/>(b)The licensee is legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. Nothing in this chapter shall in any way affect the rights and remedies available under other law.<br/>(c) Upon approving an application for an assisted living facility license, the commissioner shall issue a single license for each building that is operated by the licensee as an assisted living facility and is located at a separate address, except as provided under paragraph (d) or (e).<br/>(d) Upon approving an application for an assisted living facility license, the commissioner may issue a single license for two or more buildings on a campus that are operated by the same licensee as an assisted living facility. An assisted living facility license for a campus must identify the address and licensed resident capacity of each building located on the campus in which assisted living services are provided.<br/>(e) Upon approving an application for an assisted living facility license, the commissioner may:<br/>    (1) issue a single license for two or more buildings on a campus that are operated by the same licensee as an assisted living facility with dementia care, provided the assisted living facility for dementia care license for a campus identifies the buildings operating as assisted living facilities with dementia care; or<br/>    (2) issue a separate assisted living facility with dementia care license for a building that is on a campus and that is operating as an assisted living facility with dementia care.</p> <p>This MN Requirement is not met as evidenced by:<br/>Not reviewed during this survey.</p> | {0 100}                                                                |                                                                                                                          |  |                                                                 |



Minnesota Department of Health

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                        |                                                                                                                          |  |                                                                 |
|----------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>34822</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>R</b><br><b>01/17/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HARDING PLACE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>24448 296TH AVENUE<br/>PIERZ, MN 56364</b>                                   |  |                                                                 |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                        |
| {0 100}                                                  | Continued From page 2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | {0 100}                                                                |                                                                                                                          |  |                                                                 |
| {0 460}<br>SS=F                                          | <b>144G.41 Subdivision 1 Minimum requirements</b><br><br>(5) provide a means for residents to request assistance for health and safety needs 24 hours per day, seven days per week;<br>(6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract;<br>(7) permit residents access to food at any time;<br>(8) allow residents to choose the resident's visitors and times of visits;<br>(9) allow the resident the right to choose a roommate if sharing a unit;<br>(10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living facility must not lock a resident in the resident's unit;<br><br>This MN Requirement is not met as evidenced by:<br>Not reviewed during this survey. | {0 460}                                                                |                                                                                                                          |  |                                                                 |
| {0 470}<br>SS=F                                          | <b>144G.41 Subdivision 1 Minimum requirements</b><br><br>(11) develop and implement a staffing plan for determining its staffing level that:<br>(i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility;<br>(ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | {0 470}                                                                |                                                                                                                          |  |                                                                 |



Minnesota Department of Health

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                        |                                                                                                                          |  |                                                                    |
|----------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34822</b>              | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>01/17/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HARDING PLACE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>24448 296TH AVENUE<br/>PIERZ, MN 56364</b> |                                                                                                                          |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ID<br>PREFIX<br>TAG                                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                           |
| {0 470}                                                  | Continued From page 3<br><br>on a 24-hour per day basis; and<br>(iii) ensures that the facility can respond promptly<br>and effectively to individual resident emergencies<br>and to emergency, life safety, and disaster<br>situations affecting staff or residents in the facility;<br>(12) ensure that one or more persons are<br>available 24 hours per day, seven days per week,<br>who are responsible for responding to the<br>requests of residents for assistance with health or<br>safety needs. Such persons must be:<br>(i) awake;<br>(ii) located in the same building, in an attached<br>building, or on a contiguous campus with the<br>facility in order to respond within a reasonable<br>amount of time;<br>(iii) capable of communicating with residents;<br>(iv) capable of providing or summoning the<br>appropriate assistance; and<br>(v) capable of following directions;<br><br>This MN Requirement is not met as evidenced<br>by:<br>Not reviewed during this survey. | {0 470}                                                                                |                                                                                                                          |  |                                                                    |
| {0 480}<br>SS=F                                          | 144G.41 Subdivision 1 Subd. 1a (a-b) Minimum<br>requirements; required food services<br><br>(a) Except as provided in paragraph (b), food<br>must be prepared and served according to the<br>Minnesota Food Code, Minnesota Rules, chapter<br>4626.<br>(b) For an assisted living facility with a licensed<br>capacity of ten or fewer residents:<br>(1) notwithstanding Minnesota Rules, part<br>4626.0033, item A, the facility may share a<br>certified food protection manager (CFPM) with<br>one other facility located within a 60-mile radius<br>and under common management provided the<br>CFPM is present at each facility frequently                                                                                                                                                                                                                                                                                                                                                 | {0 480}                                                                                |                                                                                                                          |  |                                                                    |



Minnesota Department of Health

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                        |                                                                                                                          |  |                                                                    |
|----------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34822</b>              | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>01/17/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HARDING PLACE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>24448 296TH AVENUE<br/>PIERZ, MN 56364</b> |                                                                                                                          |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ID<br>PREFIX<br>TAG                                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                           |
| {0 480}                                                  | <p>Continued From page 4</p> <p>enough to effectively administer, manage, and supervise each facility's food service operation;</p> <p>(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;</p> <p>(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;</p> <p>(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;</p> <p>(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;</p> <p>(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</p> <p>(7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door.</p> | {0 480}                                                                                |                                                                                                                          |  |                                                                    |



Minnesota Department of Health

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                        |                                                                                                                          |  |                                                                    |
|----------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34822</b>              | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>01/17/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HARDING PLACE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>24448 296TH AVENUE<br/>PIERZ, MN 56364</b> |                                                                                                                          |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | ID<br>PREFIX<br>TAG                                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                           |
| {0 480}                                                  | Continued From page 5<br><br>This MN Requirement is not met as evidenced<br>by:<br>Not reviewed during this survey.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | {0 480}                                                                                |                                                                                                                          |  |                                                                    |
| {0 640}<br>SS=F                                          | <b>144G.42 Subd. 7</b> Posting information for<br>reporting suspected c<br><br>The facility shall support protection and safety<br>through access to the state's systems for<br>reporting suspected criminal activity and<br>suspected vulnerable adult maltreatment by:<br>(1) posting the 911 emergency number in<br>common areas and near telephones provided by<br>the assisted living facility;<br>(2) posting information and the reporting number<br>for the Minnesota Adult Abuse Reporting Center<br>to report suspected maltreatment of a vulnerable<br>adult under section 626.557; and<br>(3) providing reasonable accommodations with<br>information and notices in plain language.<br><br>This MN Requirement is not met as evidenced<br>by:<br>Not reviewed during this survey. | {0 640}                                                                                |                                                                                                                          |  |                                                                    |
| {0 650}<br>SS=F                                          | <b>144G.42 Subd. 8 (a)</b> Staff records<br><br>(a) The facility must maintain current records of<br>each paid staff member, each regularly<br>scheduled volunteer providing services, and each<br>individual contractor providing services. The<br>records must include the following infomation:<br>(1) evidence of current professional licensure,<br>registration, or certification if licensure,<br>registration, or certification is required by this<br>chapter or rules;<br>(2) records of orientation, required annual training<br>and infection control training, and competency                                                                                                                                                                                                     | {0 650}                                                                                |                                                                                                                          |  |                                                                    |



Minnesota Department of Health

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                        |                                                                                                                          |  |                                                                 |
|----------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>34822</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>R</b><br><b>01/17/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HARDING PLACE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>24448 296TH AVENUE<br/>PIERZ, MN 56364</b>                                   |  |                                                                 |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                        |
| {0 650}                                                  | Continued From page 6<br><br>evaluations;<br>(3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision;<br>(4) documentation of annual performance reviews that identify areas of improvement needed and training needs;<br>(5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and<br>(6) documentation of the background study as required under section 144.057.<br><br>This MN Requirement is not met as evidenced by:<br>Not reviewed during this survey.                                                                                                                                                                            | {0 650}                                                                |                                                                                                                          |  |                                                                 |
| {0 660}<br>SS=F                                          | 144G.42 Subd. 9 Tuberculosis prevention and control<br><br>(a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines.<br>(b) The facility must maintain written evidence of compliance with this subdivision.<br><br>This MN Requirement is not met as evidenced | {0 660}                                                                |                                                                                                                          |  |                                                                 |



Minnesota Department of Health

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                        |                                                                                                                          |  |                                                                    |
|----------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34822</b>              | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>01/17/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HARDING PLACE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>24448 296TH AVENUE<br/>PIERZ, MN 56364</b> |                                                                                                                          |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ID<br>PREFIX<br>TAG                                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                           |
| {0 660}                                                  | Continued From page 7<br><br>by:<br>Not reviewed during this survey.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | {0 660}                                                                                |                                                                                                                          |  |                                                                    |
| {0 680}<br>SS=F                                          | <b>144G.42 Subd. 10 Disaster planning and<br/>emergency preparedness</b><br><br>(a) The facility must meet the following<br>requirements:<br>(1) have a written emergency disaster plan that<br>contains a plan for evacuation, addresses<br>elements of sheltering in place, identifies<br>temporary relocation sites, and details staff<br>assignments in the event of a disaster or an<br>emergency;<br>(2) post an emergency disaster plan prominently;<br>(3) provide building emergency exit diagrams to<br>all residents;<br>(4) post emergency exit diagrams on each floor;<br>and<br>(5) have a written policy and procedure regarding<br>missing residents.<br>(b) The facility must provide emergency and<br>disaster training to all staff during the initial staff<br>orientation and annually thereafter and must<br>make emergency and disaster training annually<br>available to all residents. Staff who have not<br>received emergency and disaster training are<br>allowed to work only when trained staff are also<br>working on site.<br>(c) The facility must meet any additional<br>requirements adopted in rule.<br><br>This MN Requirement is not met as evidenced<br>by:<br>Not reviewed during this survey. | {0 680}                                                                                |                                                                                                                          |  |                                                                    |
| {0 730}<br>SS=F                                          | <b>144G.43 Subd. 3 Contents of resident record</b><br><br>Contents of a resident record include the                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | {0 730}                                                                                |                                                                                                                          |  |                                                                    |



Minnesota Department of Health

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                           |                                                                                                                          |  |                                                                    |
|----------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34822</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>01/17/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HARDING PLACE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                           | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>24448 296TH AVENUE<br/>PIERZ, MN 56364</b>                                   |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ID<br>PREFIX<br>TAG                                                       | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                           |
| {0 730}                                                  | <p>Continued From page 8</p> <p>following for each resident:</p> <p>(1) identifying information, including the resident's name, date of birth, address, and telephone number;</p> <p>(2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative;</p> <p>(3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known;</p> <p>(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;</p> <p>(5) the resident's advance directives, if any;</p> <p>(6) copies of any health care directives, guardianships, powers of attorney, or conservatorships;</p> <p>(7) the facility's current and previous assessments and service plans;</p> <p>(8) all records of communications pertinent to the resident's services;</p> <p>(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;</p> <p>(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;</p> <p>(11) documentation that services have been provided as identified in the service plan;</p> <p>(12) documentation that the resident has received and reviewed the assisted living bill of rights;</p> <p>(13) documentation of complaints received and any resolution;</p> | {0 730}                                                                   |                                                                                                                          |  |                                                                    |



Minnesota Department of Health

|                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                 |                                                                                                                          |                          |                                                   |
|---------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|---------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>34822 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |                          | (X3) DATE SURVEY COMPLETED<br><br>R<br>01/17/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>HARDING PLACE |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br>24448 296TH AVENUE<br>PIERZ, MN 56364                                           |                          |                                                   |
| (X4) ID<br>PREFIX<br>TAG                          | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ID<br>PREFIX<br>TAG                                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                   |
| {0 730}                                           | Continued From page 9<br><br>(14) a discharge summary, including service termination notice and related documentation, when applicable; and<br>(15) other documentation required under this chapter and relevant to the resident's services or status.<br><br>This MN Requirement is not met as evidenced by:<br>Not reviewed during this survey.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | {0 730}                                                         |                                                                                                                          |                          |                                                   |
| {0 780}<br>SS=F                                   | 144G.45 Subd. 2 (a) (1) Fire protection and physical environment<br><br>for dwellings or sleeping units, as defined in the State Fire Code:<br>(i) provide smoke alarms in each room used for sleeping purposes;<br>(ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms;<br>(iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics;<br>(iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and<br>(v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; | {0 780}                                                         |                                                                                                                          |                          |                                                   |



Minnesota Department of Health

|                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                |                                                                                                                          |  |                                                   |
|---------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>34822                | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br>R<br>01/17/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>HARDING PLACE |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | STREET ADDRESS, CITY, STATE, ZIP CODE<br>24448 296TH AVENUE<br>PIERZ, MN 56364 |                                                                                                                          |  |                                                   |
| (X4) ID<br>PREFIX<br>TAG                          | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                          |
| {0 780}                                           | <p>Continued From page 10</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on observation and record review, the licensee failed to comply with Minnesota State Fire Code. This had the potential to directly affect all residents, staff, and visitors.</p> <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) 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).</p> <p>The findings include:</p> <p>On January 17, 2025, the surveyor emailed the licensee requesting documentation for corrections completed for the obstructed means of egress in the corridor outside resident sleeping areas 1, 2, 3, 4, 5, and 6.</p> <p>On January 27, 2025, the licensee responded that most of the couches and chairs had been moved, paving the way for easier egress. Photos of this corridor were emailed to the surveyor. The photos indicted furniture had been removed from one side of the corridor. The photos showed several pieces of upholstered furniture, a wood table, and a lamp stored along one side of the corridor. A means of egress shall be free from obstruction. Means of egress shall remain free of any material or matter where its presence would obstruct or render the means of egress hazardous.</p> | {0 780}                                                                        |                                                                                                                          |  |                                                   |



Minnesota Department of Health

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                        |                                                                                                                          |  |                                                                 |
|----------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>34822</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>R</b><br><b>01/17/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HARDING PLACE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>24448 296TH AVENUE<br/>PIERZ, MN 56364</b>                                   |  |                                                                 |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                        |
| {0 800}                                                  | Continued From page 11                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | {0 800}                                                                |                                                                                                                          |  |                                                                 |
| {0 800}<br>SS=F                                          | <p>144G.45 Subd. 2 (a) (4) Fire protection and physical environment</p> <p>(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.</p> <p>This MN Requirement is not met as evidenced by:<br/>Not reviewed during this survey.</p>                                                                                                                                                                                                                                                                                                                                                                                                                        | {0 800}                                                                |                                                                                                                          |  |                                                                 |
| {0 810}<br>SS=F                                          | <p>144G.45 Subd. 2 (b-f) Fire protection and physical environment</p> <p>(b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to:<br/>(1) location and number of resident sleeping rooms;<br/>(2) staff actions to be taken in the event of a fire or similar emergency;<br/>(3) fire protection procedures necessary for residents; and<br/>(4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation.<br/>(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.<br/>(d) Fire safety and evacuation plans shall be readily available at all times within the facility.</p> | {0 810}                                                                |                                                                                                                          |  |                                                                 |



Minnesota Department of Health  
STATE FORM 6899 42|Z13 If continuation sheet 13 of 23



Minnesota Department of Health

|                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                |                                                                                                                          |  |                                                   |
|---------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>34822                | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br>R<br>01/17/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>HARDING PLACE |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br>24448 296TH AVENUE<br>PIERZ, MN 56364 |                                                                                                                          |  |                                                   |
| (X4) ID<br>PREFIX<br>TAG                          | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                          |
| {0 830}                                           | Continued From page 13<br><br>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).<br><br>The findings include:<br><br>On January 17, 2025, the surveyor emailed the licensee requesting documentation to support that a plan review application had been submitted to Minnesota Department of Health Engineering Services for a new interior wall constructed in front of the apartment door on the upper floor of the facility.<br><br>On January 17, 2025, the surveyor emailed the licensee requesting documentation to support corrections that had been completed for the violations listed in the state fire marshal inspection report dated October 16, 2024. This report listed the building in violation of MSFC 2020-102.4.<br><br>On January 27, 2025, the licensee responded that an e-mail was sent to the architect on January 23, 2025, and we are awaiting that report from him.<br><br>As of February 4, 2025, a plan review application had not been submitted to Minnesota Department of Health Engineering Services. | {0 830}                                                                        |                                                                                                                          |  |                                                   |
| {0 910}<br>SS=C                                   | 144G.50 Subd. 2 (a-b) Contract information<br><br>(a) The contract must include in a conspicuous place and manner on the contract the legal name                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | {0 910}                                                                        |                                                                                                                          |  |                                                   |



Minnesota Department of Health

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                        |                                                                                                                          |  |                                                                    |
|----------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34822</b>              | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>01/17/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HARDING PLACE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>24448 296TH AVENUE<br/>PIERZ, MN 56364</b> |                                                                                                                          |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ID<br>PREFIX<br>TAG                                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                           |
| {0 910}                                                  | Continued From page 14<br><br>and the health facility identification of the facility.<br>(b) The contract must include the name,<br>telephone number, and physical mailing address,<br>which may not be a public or private post office<br>box, of:<br>(1) the facility and contracted service provider<br>when applicable;<br>(2) the licensee of the facility;<br>(3) the managing agent of the facility, if<br>applicable; and<br>(4) the authorized agent for the facility.<br><br>This MN Requirement is not met as evidenced<br>by:<br>Not reviewed during this survey.                                                                                                                                                                                                                                                                                                                                                                                                                                                     | {0 910}                                                                                |                                                                                                                          |  |                                                                    |
| {0 920}<br>SS=C                                          | 144G.50 Subd. 2 (c) Contract information<br><br>(c) The contract must include:<br>(1) a disclosure of the category of assisted living<br>facility license held by the facility and, if the facility<br>is not an assisted living facility with dementia<br>care, a disclosure that it does not hold an<br>assisted living facility with dementia care license;<br>(2) a description of all the terms and conditions of<br>the contract, including a description of and any<br>limitations to the housing or assisted living<br>services to be provided for the contracted<br>amount;<br>(3) a delineation of the cost and nature of any<br>other services to be provided for an additional<br>fee;<br>(4) a delineation and description of any additional<br>fees the resident may be required to pay if the<br>resident's condition changes during the term of<br>the contract;<br>(5) a delineation of the grounds under which the<br>resident may be transferred or have housing or<br>services terminated or be subject to an | {0 920}                                                                                |                                                                                                                          |  |                                                                    |



Minnesota Department of Health

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                        |                                                                                                                          |  |                                                                    |
|----------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34822</b>              | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>01/17/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HARDING PLACE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>24448 296TH AVENUE<br/>PIERZ, MN 56364</b> |                                                                                                                          |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ID<br>PREFIX<br>TAG                                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                           |
| {0 920}                                                  | Continued From page 15<br><br>emergency relocation;<br>(6) billing and payment procedures and<br>requirements; and<br>(7) disclosure of the facility's ability to provide<br>specialized diets.<br><br>This MN Requirement is not met as evidenced<br>by:<br>Not reviewed during this survey.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | {0 920}                                                                                |                                                                                                                          |  |                                                                    |
| {0 930}<br>SS=C                                          | 144G.50 Subd. 2 (d-e; 1-4) Contract information<br><br>(d) The contract must include a description of the<br>facility's complaint resolution process available to<br>residents, including the name and contact<br>information of the person representing the facility<br>who is designated to handle and resolve<br>complaints.<br>(e) The contract must include a clear and<br>conspicuous notice of:<br>(1) the right under section 144G.54 to appeal the<br>termination of an assisted living contract;<br>(2) the facility's policy regarding transfer of<br>residents within the facility, under what<br>circumstances a transfer may occur, and the<br>circumstances under which resident consent is<br>required for a transfer;<br>(3) contact information for the Office of<br>Ombudsman for Long-Term Care, the<br>Ombudsman for Mental Health and<br>Developmental Disabilities, and the Office of<br>Health Facility Complaints;<br>(4) the resident's right to obtain services from an<br>unaffiliated service provider;<br><br>This MN Requirement is not met as evidenced<br>by:<br>Not reviewed during this survey. | {0 930}                                                                                |                                                                                                                          |  |                                                                    |



Minnesota Department of Health

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                           |                                                                                                                          |  |                                                                    |
|----------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34822</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>01/17/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HARDING PLACE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                           | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>24448 296TH AVENUE<br/>PIERZ, MN 56364</b>                                   |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | ID<br>PREFIX<br>TAG                                                       | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                           |
| {0 940}                                                  | Continued From page 16                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | {0 940}                                                                   |                                                                                                                          |  |                                                                    |
| {0 940}<br>SS=C                                          | <b>144G.50 Subd. 2 (e; 5-7) Contract information</b><br><br>(5) a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including:<br>(i) whether the facility is enrolled with the commissioner of human services to provide customized living services under medical assistance waivers;<br>(ii) whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b);<br>(iii) whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided;<br>(iv) whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required;<br>(v) a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent;<br>(vi) a statement that residents may be eligible for assistance with rent through the housing support program; and<br>(vii) a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program;<br>(6) the contact information to obtain long-term care consulting services under section 256B.0911; and<br>(7) the toll-free phone number for the Minnesota Adult Abuse Reporting Center. | {0 940}                                                                   |                                                                                                                          |  |                                                                    |



Minnesota Department of Health

|                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                |                                                                                                                          |  |                                                   |
|---------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>34822                | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br>R<br>01/17/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>HARDING PLACE |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | STREET ADDRESS, CITY, STATE, ZIP CODE<br>24448 296TH AVENUE<br>PIERZ, MN 56364 |                                                                                                                          |  |                                                   |
| (X4) ID<br>PREFIX<br>TAG                          | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                          |
| {0 940}                                           | Continued From page 17<br><br>This MN Requirement is not met as evidenced by:<br>Not reviewed during this survey.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | {0 940}                                                                        |                                                                                                                          |  |                                                   |
| {0 950}<br>SS=C                                   | 144G.50 Subd. 3 Designation of representative<br><br>(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:<br><br>"RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES.<br><br>You have the right to name anyone as your "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."<br><br>(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.<br><br>This MN Requirement is not met as evidenced by: | {0 950}                                                                        |                                                                                                                          |  |                                                   |



Minnesota Department of Health

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                        |                                                                                                                          |  |                                                                    |
|----------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34822</b>              | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>01/17/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HARDING PLACE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>24448 296TH AVENUE<br/>PIERZ, MN 56364</b> |                                                                                                                          |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ID<br>PREFIX<br>TAG                                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                           |
| {0 950}                                                  | Continued From page 18<br><br>Not reviewed during this survey.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | {0 950}                                                                                |                                                                                                                          |  |                                                                    |
| {0 970}<br>SS=C                                          | <b>144G.50 Subd. 5</b> Waivers of liability prohibited<br><br>The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law.<br><br>This MN Requirement is not met as evidenced by:<br>Not reviewed during this survey.                                                                                                                                                                                                                                                                                                                                                                                          | {0 970}                                                                                |                                                                                                                          |  |                                                                    |
| {01500}<br>SS=F                                          | <b>144G.63 Subd. 5</b> Required annual training<br><br>(a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include:<br>(1) training on reporting of maltreatment of vulnerable adults under section 626.557;<br>(2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights;<br>(3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor | {01500}                                                                                |                                                                                                                          |  |                                                                    |



Minnesota Department of Health

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                        |                                                                                                                          |  |                                                                 |
|----------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>34822</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>R</b><br><b>01/17/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HARDING PLACE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>24448 296TH AVENUE<br/>PIERZ, MN 56364</b>                                   |  |                                                                 |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                        |
| {01500}                                                  | <p>Continued From page 19</p> <p>blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases;</p> <p>(4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders;</p> <p>(5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and</p> <p>(6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person.</p> <p>(b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics:</p> <p>(1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication;</p> <p>(2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or</p> <p>(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.</p> <p>This MN Requirement is not met as evidenced by:<br/>Not reviewed during this survey.</p> | {01500}                                                                |                                                                                                                          |  |                                                                 |



Minnesota Department of Health

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                        |                                                                                                                          |  |                                                                 |
|----------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>34822</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>R</b><br><b>01/17/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HARDING PLACE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>24448 296TH AVENUE<br/>PIERZ, MN 56364</b>                                   |  |                                                                 |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                        |
| {01500}                                                  | Continued From page 20                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | {01500}                                                                |                                                                                                                          |  |                                                                 |
| {01530}<br>SS=D                                          | <b>144G.64 TRAINING IN DEMENTIA CARE<br/>REQUIRED</b><br><br>(a) All assisted living facilities must meet the following training requirements:<br>(1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter;<br>(2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter;<br><br>This MN Requirement is not met as evidenced by:<br>Not reviewed during this survey. | {01530}                                                                |                                                                                                                          |  |                                                                 |
| {01910}<br>SS=D                                          | <b>144G.71 Subd. 22 Disposition of medications</b><br><br>(a) Any current medications being managed by the assisted living facility must be provided to the                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | {01910}                                                                |                                                                                                                          |  |                                                                 |



Minnesota Department of Health

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                        |                                                                                                                          |  |                                                                    |
|----------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34822</b>              | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>01/17/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HARDING PLACE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>24448 296TH AVENUE<br/>PIERZ, MN 56364</b> |                                                                                                                          |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | ID<br>PREFIX<br>TAG                                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                           |
| {01910}                                                  | <p>Continued From page 21</p> <p>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.</p> <p>(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 medications and controlled substances.</p> <p>(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.</p> <p>This MN Requirement is not met as evidenced by:<br/>Not reviewed during this survey.</p> | {01910}                                                                                |                                                                                                                          |  |                                                                    |
| {02320}<br>SS=D                                          | <p><b>144G.91 Subd. 4 (b) Appropriate care and services</b></p> <p>(b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan.</p> <p>This MN Requirement is not met as evidenced by:<br/>Not reviewed during this survey.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | {02320}                                                                                |                                                                                                                          |  |                                                                    |



Minnesota Department of Health

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                           |                                                                                                                          |                          |                                                                    |
|----------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34822</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>01/17/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HARDING PLACE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                           | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>24448 296TH AVENUE<br/>PIERZ, MN 56364</b>                                   |                          |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                   | ID<br>PREFIX<br>TAG                                                       | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                                    |
| {02420}                                                  | Continued From page 22                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | {02420}                                                                   |                                                                                                                          |                          |                                                                    |
| {02420}<br>SS=F                                          | <b>144G.91 Subd. 14 Communication privacy</b><br><br>(a) Residents have the right to communicate<br>privately with persons of their choice.<br>(b) If an assisted living facility is sending or<br>receiving mail on behalf of residents, the assisted<br>living facility must do so without interference.<br>(c) Residents must be provided access to a<br>telephone to make and receive calls.<br><br>This MN Requirement is not met as evidenced<br>by:<br>Not reviewed during this survey. | {02420}                                                                   |                                                                                                                          |                          |                                                                    |





*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically Delivered

December 31, 2024

Licensee  
Harding Place  
24448 296th Avenue  
Pierz, MN 56364

RE: Project Number(s) SL34822015

Dear Licensee:

On October 2, 2024, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on July 11, 2024. This follow-up survey determined your facility had corrected all of the state correction orders issued pursuant to the July 11, 2024 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on July 11, 2024, found not corrected at the time of the October 2, 2024, follow-up survey and/or subject to penalty assessment are as follows:

**0780 - Fire Protection And Physical Environment - 144g.45 Subd. 2 (a) (1) - \$500.00**

The details of the violations noted at the time of this follow-up survey completed on October 2, 2024 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

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

Also, at the time of this follow-up survey completed on October 2, 2024, we identified the following violation(s):

**0100 - License Required - 144g.10 Subdivision 1**

**0830 - Local Laws Apply - 144g.45 Subd. 3**

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

**DOCUMENTATION OF ACTION TO COMPLY**

In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to



comply with the correction orders outlined on the state form; however, plans of correction are not required to be submitted for approval.

#### **IMPOSITION OF FINES:**

Level 1: no fines or enforcement.

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

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

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

#### **CORRECTION ORDER RECONSIDERATION PROCESS**

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

To submit a reconsideration request, please visit:

**<https://forms.web.health.state.mn.us/form/HRDAppealsForm>**

#### **REQUESTING A HEARING**

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

To submit a hearing request, please visit:

**<https://forms.web.health.state.mn.us/form/HRDAppealsForm>**

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

#### **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 Harding Place. Please contact Amy Hyers at 651-443-2878 on or before Friday, January 3, 2025, to schedule the conference call.



We urge you to review these orders carefully. If you have questions, please contact Benjamin J. Zwart at 651-201-3715.

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

Sincerely,

A handwritten signature in black ink that reads "Benjamin Zwart". The signature is written in a cursive style with a horizontal line extending from the end of the name.

Benjamin J. Zwart, P.E., Supervisor  
State Engineering Services Section  
Health Regulation Division  
Email: Benjamin.Zwart@state.mn.us  
Telephone: 651-201-3715 Fax: 1-866-890-9290

JMD



Minnesota Department of Health

|                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                    |                                                   |
|---------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------|---------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>34822 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                    | (X3) DATE SURVEY COMPLETED<br><br>R<br>10/02/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>HARDING PLACE |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br>24448 296TH AVENUE<br>PIERZ, MN 56364                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                    |                                                   |
| (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}                                           | <p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER</p> <p>In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey.</p> <p>Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance.</p> <p>INITIAL COMMENTS:</p> <p>SL#34822015-1</p> <p>On October 2, 2024, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on July 11, 2024. At the time of the survey, there were eighteen (18) residents all of whom received services under the Assisted Living license. As a result of the follow-up survey, the following orders were reissued.</p> | {0 000}                                                         | <p>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.</p> <p>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.</p> <p>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.</p> <p>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.</p> |                    |                                                   |
| 0 100<br>SS=F                                     | 144G.10 Subdivision 1 License required<br><br>(a)(1)Beginning August 1, 2021, no assisted living                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 0 100                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                    |                                                   |

Minnesota Department of Health

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

TITLE

(X6) DATE



Minnesota Department of Health

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                        |                                                                                                                          |  |                                                                    |
|----------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34822</b>              | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>10/02/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HARDING PLACE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>24448 296TH AVENUE<br/>PIERZ, MN 56364</b> |                                                                                                                          |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ID<br>PREFIX<br>TAG                                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                           |
| 0 100                                                    | <p>Continued From page 1</p> <p>facility may operate in Minnesota unless it is licensed under this chapter.</p> <p>(2) No facility or building on a campus may provide assisted living services until obtaining the required license under paragraphs (c) to (e).</p> <p>(b)The licensee is legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. Nothing in this chapter shall in any way affect the rights and remedies available under other law.</p> <p>(c) Upon approving an application for an assisted living facility license, the commissioner shall issue a single license for each building that is operated by the licensee as an assisted living facility and is located at a separate address, except as provided under paragraph (d) or (e).</p> <p>(d) Upon approving an application for an assisted living facility license, the commissioner may issue a single license for two or more buildings on a campus that are operated by the same licensee as an assisted living facility. An assisted living facility license for a campus must identify the address and licensed resident capacity of each building located on the campus in which assisted living services are provided.</p> <p>(e) Upon approving an application for an assisted living facility license, the commissioner may:</p> <p>(1) issue a single license for two or more buildings on a campus that are operated by the same licensee as an assisted living facility with dementia care, provided the assisted living facility for dementia care license for a campus identifies the buildings operating as assisted living facilities with dementia care; or</p> <p>(2) issue a separate assisted living facility with dementia care license for a building that is on a campus and that is operating as an assisted living facility with dementia care.</p> | 0 100                                                                                  |                                                                                                                          |  |                                                                    |



Minnesota Department of Health

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                        |                                                                                                                          |  |                                                                    |
|----------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34822</b>              | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>10/02/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HARDING PLACE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>24448 296TH AVENUE<br/>PIERZ, MN 56364</b> |                                                                                                                          |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ID<br>PREFIX<br>TAG                                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                           |
| 0 100                                                    | <p>Continued From page 2</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on observation and interview the licensee operated as an assisted living facility despite housing a mixed occupancy of assisted living residents with an adjoining apartment with none residents within one structure/roof.</p> <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 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).</p> <p>The findings include:</p> <p>On September 30, 2024, at 1:31 p.m., the engineering surveyor sent an email which indicated while on site for a follow up survey they had observed in the upstairs two-bedroom apartment the following: television set was on, dirty dishes in the kitchen sink, and the apartment was full of personal belongings including children's toys.</p> <p>On October 2, 2024, at 10:24 a.m., the surveyor toured the apartment and observed and took pictures of the following: children's toys, dishes on the kitchen sink, a disposable plate on the coffe table, a shawl/blanket on the coach, a portable gas generator, and the apartment was full of personal belongings.</p> <p>On October 2, 2024, at 10:28 a.m., the surveyor</p> | 0 100                                                                                  |                                                                                                                          |  |                                                                    |



Minnesota Department of Health

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                        |                                                                                                                          |  |                                                                    |
|----------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34822</b>              | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>10/02/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HARDING PLACE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>24448 296TH AVENUE<br/>PIERZ, MN 56364</b> |                                                                                                                          |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ID<br>PREFIX<br>TAG                                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                           |
| 0 100                                                    | <p>Continued From page 3</p> <p>requested to know what happened in the apartment, licensed assisted living director in training (LALDT)-H stated someone was living there, but the licensee's administration was working to ensure if that was okay. LALDT-H also stated he was not sure if the person who lived there had children, but he had occasionally seen a child play on the balcony.</p> <p>On October 2, 2024, at 10:44 a.m., over a phone interview licensed assisted living director (LALD)-A stated someone was supposed to live in the apartment but was not sure if they had moved in yet. LALD-A also stated the person was allowed to move their furniture meanwhile into the apartment, awaiting determination whether it was okay or not to live there. LALD-A also stated they did not have a lease signed with the person as they were waiting on appropriate coding before signing the lease.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days</p> | 0 100                                                                                  |                                                                                                                          |  |                                                                    |
| {0 460}<br>SS=F                                          | <p>144G.41 Subdivision 1 Minimum requirements</p> <p>(5) provide a means for residents to request assistance for health and safety needs 24 hours per day, seven days per week;</p> <p>(6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract;</p> <p>(7) permit residents access to food at any time;</p> <p>(8) allow residents to choose the resident's visitors and times of visits;</p> <p>(9) allow the resident the right to choose a roommate if sharing a unit;</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | {0 460}                                                                                |                                                                                                                          |  |                                                                    |



Minnesota Department of Health

|                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                |                                                                                                                          |  |                                                   |
|---------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>34822                | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br>R<br>10/02/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>HARDING PLACE |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | STREET ADDRESS, CITY, STATE, ZIP CODE<br>24448 296TH AVENUE<br>PIERZ, MN 56364 |                                                                                                                          |  |                                                   |
| (X4) ID<br>PREFIX<br>TAG                          | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                          |
| {0 460}                                           | Continued From page 4<br><br>(10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living facility must not lock a resident in the resident's unit;<br><br>This MN Requirement is not met as evidenced by:<br>No further action required                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | {0 460}                                                                        |                                                                                                                          |  |                                                   |
| {0 470}<br>SS=F                                   | 144G.41 Subdivision 1 Minimum requirements<br><br>(11) develop and implement a staffing plan for determining its staffing level that:<br>(i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility;<br>(ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and<br>(iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility;<br>(12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be:<br>(i) awake;<br>(ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable | {0 470}                                                                        |                                                                                                                          |  |                                                   |



Minnesota Department of Health

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                        |                                                                                                                          |  |                                                                    |
|----------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34822</b>              | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>10/02/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HARDING PLACE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>24448 296TH AVENUE<br/>PIERZ, MN 56364</b> |                                                                                                                          |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ID<br>PREFIX<br>TAG                                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                           |
| {0 470}                                                  | Continued From page 5<br><br>amount of time;<br>(iii) capable of communicating with residents;<br>(iv) capable of providing or summoning the<br>appropriate assistance; and<br>(v) capable of following directions;<br><br>This MN Requirement is not met as evidenced<br>by:<br>No further action required                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | {0 470}                                                                                |                                                                                                                          |  |                                                                    |
| {0 480}<br>SS=F                                          | <b>144G.41</b> Subdivision 1 Subd. 1a (a-b) Minimum<br>requirements; required food services<br><br>(a) Except as provided in paragraph (b), food<br>must be prepared and served according to the<br>Minnesota Food Code, Minnesota Rules, chapter<br>4626.<br>(b) For an assisted living facility with a licensed<br>capacity of ten or fewer residents:<br>(1) notwithstanding Minnesota Rules, part<br>4626.0033, item A, the facility may share a<br>certified food protection manager (CFPM) with<br>one other facility located within a 60-mile radius<br>and under common management provided the<br>CFPM is present at each facility frequently<br>enough to effectively administer, manage, and<br>supervise each facility's food service operation;<br>(2) notwithstanding Minnesota Rules, part<br>4626.0545, item A, kick plates that are not<br>removable or cannot be rotated open are allowed<br>unless the facility has been issued repeated<br>correction orders for violations of Minnesota<br>Rules, part 4626.1565 or 4626.1570;<br>(3) notwithstanding Minnesota Rules, part<br>4626.0685, item A, the facility is not required to<br>provide integral drainboards, utensil racks, or<br>tables large enough to accommodate soiled and<br>clean items that may accumulate during hours of<br>operation provided soiled items do not | {0 480}                                                                                |                                                                                                                          |  |                                                                    |



Minnesota Department of Health

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                        |                                                                                                                          |  |                                                                    |
|----------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34822</b>              | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>10/02/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HARDING PLACE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>24448 296TH AVENUE<br/>PIERZ, MN 56364</b> |                                                                                                                          |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | ID<br>PREFIX<br>TAG                                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                           |
| {0 480}                                                  | Continued From page 6<br><br>contaminate clean items, surfaces, or food, and<br>clean equipment and dishes are air dried in a<br>manner that prevents contamination before<br>storage;<br>(4) notwithstanding Minnesota Rules, part<br>4626.1070, item A, the facility is not required to<br>install a dedicated handwashing sink in its<br>existing kitchen provided it designates one well of<br>a two-compartment sink for use only as a<br>handwashing sink;<br>(5) notwithstanding Minnesota Rules, parts<br>4626.1325, 4626.1335, and 4626.1360, item A,<br>existing floor, wall, and ceiling finishes are<br>allowed provided the facility keeps them clean<br>and in good condition;<br>(6) notwithstanding Minnesota Rules, part<br>4626.1375, shielded or shatter-resistant<br>lightbulbs are not required, but if a light bulb<br>breaks, the facility must discard all exposed food<br>and fully clean all equipment, dishes, and<br>surfaces to remove any glass particles; and<br>(7) notwithstanding Minnesota Rules, part<br>4626.1390, toilet rooms are not required to be<br>provided with a self-closing door.<br><br>This MN Requirement is not met as evidenced<br>by:<br>No further action required | {0 480}                                                                                |                                                                                                                          |  |                                                                    |
| {0 640}<br>SS=F                                          | 144G.42 Subd. 7 Posting information for<br>reporting suspected c<br><br>The facility shall support protection and safety<br>through access to the state's systems for<br>reporting suspected criminal activity and<br>suspected vulnerable adult maltreatment by:<br>(1) posting the 911 emergency number in<br>common areas and near telephones provided by                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | {0 640}                                                                                |                                                                                                                          |  |                                                                    |



Minnesota Department of Health

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                           |                                                                                                                          |  |                                                                    |
|----------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34822</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>10/02/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HARDING PLACE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                           | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>24448 296TH AVENUE<br/>PIERZ, MN 56364</b>                                   |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | ID<br>PREFIX<br>TAG                                                       | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                           |
| {0 640}                                                  | Continued From page 7<br><br>the assisted living facility;<br>(2) posting information and the reporting number<br>for the Minnesota Adult Abuse Reporting Center<br>to report suspected maltreatment of a vulnerable<br>adult under section 626.557; and<br>(3) providing reasonable accommodations with<br>information and notices in plain language.<br><br>This MN Requirement is not met as evidenced<br>by:<br>No further action required                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | {0 640}                                                                   |                                                                                                                          |  |                                                                    |
| {0 650}<br>SS=F                                          | 144G.42 Subd. 8 (a) Staff records<br><br>(a) The facility must maintain current records of<br>each paid staff member, each regularly<br>scheduled volunteer providing services, and each<br>individual contractor providing services. The<br>records must include the following information:<br>(1) evidence of current professional licensure,<br>registration, or certification if licensure,<br>registration, or certification is required by this<br>chapter or rules;<br>(2) records of orientation, required annual training<br>and infection control training, and competency<br>evaluations;<br>(3) current job description, including<br>qualifications, responsibilities, and identification of<br>staff persons providing supervision;<br>(4) documentation of annual performance<br>reviews that identify areas of improvement<br>needed and training needs;<br>(5) for individuals providing assisted living<br>services, verification that required health<br>screenings under subdivision 9 have taken place<br>and the dates of those screenings; and<br>(6) documentation of the background study as<br>required under section 144.057. | {0 650}                                                                   |                                                                                                                          |  |                                                                    |



Minnesota Department of Health

|                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                |                                                                                                                          |  |                                                   |
|---------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>34822                | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br>R<br>10/02/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>HARDING PLACE |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | STREET ADDRESS, CITY, STATE, ZIP CODE<br>24448 296TH AVENUE<br>PIERZ, MN 56364 |                                                                                                                          |  |                                                   |
| (X4) ID<br>PREFIX<br>TAG                          | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                          |
| {0 650}                                           | Continued From page 8<br><br>This MN Requirement is not met as evidenced<br>by:<br>No further action required                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | {0 650}                                                                        |                                                                                                                          |  |                                                   |
| {0 660}<br>SS=F                                   | 144G.42 Subd. 9 Tuberculosis prevention and<br>control<br><br>(a) The facility must establish and maintain a<br>comprehensive tuberculosis infection control<br>program according to the most current<br>tuberculosis infection control guidelines issued by<br>the United States Centers for Disease Control<br>and Prevention (CDC), Division of Tuberculosis<br>Elimination, as published in the CDC's Morbidity<br>and Mortality Weekly Report. The program must<br>include a tuberculosis infection control plan that<br>covers all paid and unpaid employees,<br>contractors, students, and regularly scheduled<br>volunteers. The commissioner shall provide<br>technical assistance regarding implementation of<br>the guidelines.<br>(b) The facility must maintain written evidence of<br>compliance with this subdivision.<br><br>This MN Requirement is not met as evidenced<br>by:<br>No further action required | {0 660}                                                                        |                                                                                                                          |  |                                                   |
| {0 680}<br>SS=F                                   | 144G.42 Subd. 10 Disaster planning and<br>emergency preparedness<br><br>(a) The facility must meet the following<br>requirements:<br>(1) have a written emergency disaster plan that<br>contains a plan for evacuation, addresses<br>elements of sheltering in place, identifies<br>temporary relocation sites, and details staff<br>assignments in the event of a disaster or an<br>emergency;                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | {0 680}                                                                        |                                                                                                                          |  |                                                   |



Minnesota Department of Health

|                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                |                                                                                                                          |  |                                                   |
|---------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>34822                | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br>R<br>10/02/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>HARDING PLACE |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br>24448 296TH AVENUE<br>PIERZ, MN 56364 |                                                                                                                          |  |                                                   |
| (X4) ID<br>PREFIX<br>TAG                          | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                          |
| {0 680}                                           | Continued From page 9<br><br>(2) post an emergency disaster plan prominently;<br>(3) provide building emergency exit diagrams to all residents;<br>(4) post emergency exit diagrams on each floor; and<br>(5) have a written policy and procedure regarding missing residents.<br>(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.<br>(c) The facility must meet any additional requirements adopted in rule.<br><br>This MN Requirement is not met as evidenced by:<br>No further action required | {0 680}                                                                        |                                                                                                                          |  |                                                   |
| {0 730}<br>SS=F                                   | 144G.43 Subd. 3 Contents of resident record<br><br>Contents of a resident record include the following for each resident:<br>(1) identifying information, including the resident's name, date of birth, address, and telephone number;<br>(2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative;<br>(3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known;<br>(4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health                                                                                                                | {0 730}                                                                        |                                                                                                                          |  |                                                   |



Minnesota Department of Health

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                        |                                                                                                                          |  |                                                                    |
|----------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34822</b>              | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>10/02/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HARDING PLACE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>24448 296TH AVENUE<br/>PIERZ, MN 56364</b> |                                                                                                                          |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ID<br>PREFIX<br>TAG                                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                           |
| {0 730}                                                  | Continued From page 10<br><br>records;<br>(5) the resident's advance directives, if any;<br>(6) copies of any health care directives,<br>guardianships, powers of attorney, or<br>conservatorships;<br>(7) the facility's current and previous<br>assessments and service plans;<br>(8) all records of communications pertinent to the<br>resident's services;<br>(9) documentation of significant changes in the<br>resident's status and actions taken in response to<br>the needs of the resident, including reporting to<br>the appropriate supervisor or health care<br>professional;<br>(10) documentation of incidents involving the<br>resident and actions taken in response to the<br>needs of the resident, including reporting to the<br>appropriate supervisor or health care<br>professional;<br>(11) documentation that services have been<br>provided as identified in the service plan;<br>(12) documentation that the resident has received<br>and reviewed the assisted living bill of rights;<br>(13) documentation of complaints received and<br>any resolution;<br>(14) a discharge summary, including service<br>termination notice and related documentation,<br>when applicable; and<br>(15) other documentation required under this<br>chapter and relevant to the resident's services or<br>status.<br><br>This MN Requirement is not met as evidenced<br>by:<br>No further action required | {0 730}                                                                                |                                                                                                                          |  |                                                                    |
| {0 780}<br>SS=F                                          | 144G.45 Subd. 2 (a) (1) Fire protection and<br>physical environment                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | {0 780}                                                                                |                                                                                                                          |  |                                                                    |



Minnesota Department of Health

|                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                 |                                                                                                                          |                          |                                                   |
|---------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|---------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>34822 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |                          | (X3) DATE SURVEY COMPLETED<br><br>R<br>10/02/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>HARDING PLACE |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br>24448 296TH AVENUE<br>PIERZ, MN 56364                                           |                          |                                                   |
| (X4) ID<br>PREFIX<br>TAG                          | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ID<br>PREFIX<br>TAG                                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                   |
| {0 780}                                           | <p>Continued From page 11</p> <p>(a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and:</p> <p>(1) for dwellings or sleeping units, as defined in the State Fire Code:</p> <p>(i) provide smoke alarms in each room used for sleeping purposes;</p> <p>(ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms;</p> <p>(iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics;</p> <p>(iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and</p> <p>(v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated;</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on observation, record review, and interview, the licensee failed to comply with Minnesota State Fire Code. This had the potential to directly affect all residents, staff, and visitors.</p> <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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected</p> | {0 780}                                                         |                                                                                                                          |                          |                                                   |



Minnesota Department of Health

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                        |                                                                                                                          |  |                                                                    |
|----------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34822</b>              | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>10/02/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HARDING PLACE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>24448 296TH AVENUE<br/>PIERZ, MN 56364</b> |                                                                                                                          |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ID<br>PREFIX<br>TAG                                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                           |
| {0 780}                                                  | <p>Continued From page 12</p> <p>or has the potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>On October 16, 2024, at 9:00 a.m., survey staff and deputy state fire marshal toured the facility with maintenance personnel (MP)-G, licensed assisted living director in training (LALDT)-H, and licensed assisted living director (LALD)-A. During the tour, the surveyor observed couches, chairs, and tables were stored along both corridor walls outside resident sleeping areas 1, 2, 3, 4, 5, and 6. A means of egress shall be free from obstruction. Means of egress shall remain free of any material or matter where its presence would obstruct or render the means of egress hazardous. During the facility tour interview, on October 16, 2024, MP-G, LALDT-H, and LALD-A verified the above listed observation.</p> <p>Record review of the available documentation indicated that the licensee did not properly maintain the kitchen fire suppression system. The fire suppression system inspection report dated July 11, 2024, listed the 12 year hydrostatic test as deficient, this test was last completed in 2003. Kitchen fire suppression systems must be properly maintained to ensure the system will function effectively in the event of a fire.</p> <p>During the facility tour interview, on October 16, 2024, with MP-G, LALDT-H, and LALD-A, the surveyor requested copies of the most recent inspection reports with documentation of any deficiencies corrected for the fire sprinkler system and fire alarm system to be emailed once received.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7)</p> | {0 780}                                                                                |                                                                                                                          |  |                                                                    |



Minnesota Department of Health

|                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                |                                                                                                                          |  |                                                   |
|---------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>34822                | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br>R<br>10/02/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>HARDING PLACE |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | STREET ADDRESS, CITY, STATE, ZIP CODE<br>24448 296TH AVENUE<br>PIERZ, MN 56364 |                                                                                                                          |  |                                                   |
| (X4) ID<br>PREFIX<br>TAG                          | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                          |
| {0 780}                                           | Continued From page 13<br><br>days                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | {0 780}                                                                        |                                                                                                                          |  |                                                   |
| {0 800}<br>SS=F                                   | 144G.45 Subd. 2 (a) (4) Fire protection and physical environment<br><br>(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.<br><br>This MN Requirement is not met as evidenced by:<br>Not reviewed during this survey.                                                                                                                                                                                                                                                                                                              | {0 800}                                                                        |                                                                                                                          |  |                                                   |
| {0 810}<br>SS=F                                   | 144G.45 Subd. 2 (b-f) Fire protection and physical environment<br><br>(b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to:<br>(1) location and number of resident sleeping rooms;<br>(2) staff actions to be taken in the event of a fire or similar emergency;<br>(3) fire protection procedures necessary for residents; and<br>(4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation.<br>(c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. | {0 810}                                                                        |                                                                                                                          |  |                                                   |



Minnesota Department of Health

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                        |                                                                                                                          |  |                                                                    |
|----------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34822</b>              | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>10/02/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HARDING PLACE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>24448 296TH AVENUE<br/>PIERZ, MN 56364</b> |                                                                                                                          |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ID<br>PREFIX<br>TAG                                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                           |
| {0 810}                                                  | Continued From page 14<br><br>(d) Fire safety and evacuation plans shall be readily available at all times within the facility.<br>(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.<br>(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.<br><br>This MN Requirement is not met as evidenced by:<br>Not reviewed during this survey. | {0 810}                                                                                |                                                                                                                          |  |                                                                    |
| 0 830<br>SS=F                                            | 144G.45 Subd. 3 Local laws apply<br><br>Assisted living facilities shall comply with all applicable state and local governing laws, regulations, standards, ordinances, and codes for fire safety, building, and zoning requirements, except a facility with a licensed resident capacity of six or fewer is exempt from rental licensing regulations imposed by any town, municipality, or county.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation and interview, the licensee failed to comply with all applicable state and local regulations. This had the potential to directly affect all residents, staff, and visitors.                                                                                              | 0 830                                                                                  |                                                                                                                          |  |                                                                    |



Minnesota Department of Health

|                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                |                                                                                                                          |  |                                                   |
|---------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>34822                | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br>R<br>10/02/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>HARDING PLACE |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>24448 296TH AVENUE<br>PIERZ, MN 56364 |                                                                                                                          |  |                                                   |
| (X4) ID<br>PREFIX<br>TAG                          | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                          |
| 0 830                                             | <p>Continued From page 15</p> <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) 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).</p> <p>The findings include:</p> <p>On October 16, 2024, at 9:00 a.m., survey staff and deputy state fire marshal toured the facility with maintenance personnel (MP)-G, licensed assisted living director in training (LALDT)-H, and licensed assisted living director (LALD)-A. During the tour, the surveyor observed the following:</p> <ul style="list-style-type: none"><li>- A new interior wall had been constructed in front of the apartment door on the upper floor of the facility. During the facility tour interview on October 16, 2024, MP-G verified this wall had been constructed since the previous site visit on September 30, 2024. The licensee failed to submit a plan review application to Minnesota Department of Health engineering services and obtain a permit for installation of this new wall.</li><li>- A state fire marshal fire inspection report dated October 16, 2024, listed the building to be in violation of MSFC 2020-102.4. Conditions were observed that did not meet the minimum requirements of Minnesota State Fire Code. On October 21, 2024, the surveyor was copied on the state fire marshal inspection report that was emailed to the licensee.</li></ul> <p>TIME PERIOD FOR CORRECTION: Seven (7) days</p> | 0 830                                                                          |                                                                                                                          |  |                                                   |



Minnesota Department of Health

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                        |                                                                                                                          |  |                                                                    |
|----------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34822</b>              | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>10/02/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HARDING PLACE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>24448 296TH AVENUE<br/>PIERZ, MN 56364</b> |                                                                                                                          |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ID<br>PREFIX<br>TAG                                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                           |
| {0 910}                                                  | Continued From page 16                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | {0 910}                                                                                |                                                                                                                          |  |                                                                    |
| {0 910}<br>SS=C                                          | <b>144G.50 Subd. 2 (a-b) Contract information</b><br><br>(a) The contract must include in a conspicuous place and manner on the contract the legal name and the health facility identification of the facility.<br>(b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of:<br>(1) the facility and contracted service provider when applicable;<br>(2) the licensee of the facility;<br>(3) the managing agent of the facility, if applicable; and<br>(4) the authorized agent for the facility.<br><br>This MN Requirement is not met as evidenced by:<br>No further action required                                                                                                                                                    | {0 910}                                                                                |                                                                                                                          |  |                                                                    |
| {0 920}<br>SS=C                                          | <b>144G.50 Subd. 2 (c) Contract information</b><br><br>(c) The contract must include:<br>(1) a disclosure of the category of assisted living facility license held by the facility and, if the facility is not an assisted living facility with dementia care, a disclosure that it does not hold an assisted living facility with dementia care license;<br>(2) a description of all the terms and conditions of the contract, including a description of and any limitations to the housing or assisted living services to be provided for the contracted amount;<br>(3) a delineation of the cost and nature of any other services to be provided for an additional fee;<br>(4) a delineation and description of any additional fees the resident may be required to pay if the resident's condition changes during the term of | {0 920}                                                                                |                                                                                                                          |  |                                                                    |



Minnesota Department of Health

|                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                |                                                                                                                 |  |                                                   |
|---------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>34822                | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                           |  | (X3) DATE SURVEY COMPLETED<br><br>R<br>10/02/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>HARDING PLACE |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | STREET ADDRESS, CITY, STATE, ZIP CODE<br>24448 296TH AVENUE<br>PIERZ, MN 56364 |                                                                                                                 |  |                                                   |
| (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                                |
| {0 920}                                           | Continued From page 17<br><br>the contract;<br>(5) a delineation of the grounds under which the resident may be transferred or have housing or services terminated or be subject to an emergency relocation;<br>(6) billing and payment procedures and requirements; and<br>(7) disclosure of the facility's ability to provide specialized diets.<br><br>This MN Requirement is not met as evidenced by:<br>No further action required                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | {0 920}                                                                        |                                                                                                                 |  |                                                   |
| {0 930}<br>SS=C                                   | 144G.50 Subd. 2 (d-e; 1-4) Contract information<br><br>(d) The contract must include a description of the facility's complaint resolution process available to residents, including the name and contact information of the person representing the facility who is designated to handle and resolve complaints.<br>(e) The contract must include a clear and conspicuous notice of:<br>(1) the right under section 144G.54 to appeal the termination of an assisted living contract;<br>(2) the facility's policy regarding transfer of residents within the facility, under what circumstances a transfer may occur, and the circumstances under which resident consent is required for a transfer;<br>(3) contact information for the Office of Ombudsman for Long-Term Care, the Ombudsman for Mental Health and Developmental Disabilities, and the Office of Health Facility Complaints;<br>(4) the resident's right to obtain services from an unaffiliated service provider; | {0 930}                                                                        |                                                                                                                 |  |                                                   |



Minnesota Department of Health

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                        |                                                                                                                          |  |                                                                    |
|----------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34822</b>              | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>10/02/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HARDING PLACE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>24448 296TH AVENUE<br/>PIERZ, MN 56364</b> |                                                                                                                          |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | ID<br>PREFIX<br>TAG                                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                           |
| {0 930}                                                  | Continued From page 18<br><br>This MN Requirement is not met as evidenced<br>by:<br>No further action required                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | {0 930}                                                                                |                                                                                                                          |  |                                                                    |
| {0 940}<br>SS=C                                          | 144G.50 Subd. 2 (e; 5-7) Contract information<br><br>(5) a description of the facility's policies related to<br>medical assistance waivers under chapter 256S<br>and section 256B.49 and the housing support<br>program under chapter 256I, including:<br>(i) whether the facility is enrolled with the<br>commissioner of human services to provide<br>customized living services under medical<br>assistance waivers;<br>(ii) whether the facility has an agreement to<br>provide housing support under section 256I.04,<br>subdivision 2, paragraph (b);<br>(iii) whether there is a limit on the number of<br>people residing at the facility who can receive<br>customized living services or participate in the<br>housing support program at any point in time. If<br>so, the limit must be provided;<br>(iv) whether the facility requires a resident to pay<br>privately for a period of time prior to accepting<br>payment under medical assistance waivers or the<br>housing support program, and if so, the length of<br>time that private payment is required;<br>(v) a statement that medical assistance waivers<br>provide payment for services, but do not cover<br>the cost of rent;<br>(vi) a statement that residents may be eligible for<br>assistance with rent through the housing support<br>program; and<br>(vii) a description of the rent requirements for<br>people who are eligible for medical assistance<br>waivers but who are not eligible for assistance<br>through the housing support program;<br>(6) the contact information to obtain long-term<br>care consulting services under section | {0 940}                                                                                |                                                                                                                          |  |                                                                    |



Minnesota Department of Health

|                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                |                                                                                                                          |  |                                                   |
|---------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>34822                | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br>R<br>10/02/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>HARDING PLACE |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>24448 296TH AVENUE<br>PIERZ, MN 56364 |                                                                                                                          |  |                                                   |
| (X4) ID<br>PREFIX<br>TAG                          | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                          |
| {0 940}                                           | Continued From page 19<br><br>256B.0911; and<br>(7) the toll-free phone number for the Minnesota Adult Abuse Reporting Center.<br><br>This MN Requirement is not met as evidenced by:<br>No further action required                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | {0 940}                                                                        |                                                                                                                          |  |                                                   |
| {0 950}<br>SS=C                                   | 144G.50 Subd. 3 Designation of representative<br><br>(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:<br><br>"RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES.<br><br>You have the right to name anyone as your "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."<br><br>(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 | {0 950}                                                                        |                                                                                                                          |  |                                                   |



Minnesota Department of Health

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                        |                                                                                                                          |  |                                                                    |
|----------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34822</b>              | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>10/02/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HARDING PLACE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>24448 296TH AVENUE<br/>PIERZ, MN 56364</b> |                                                                                                                          |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | ID<br>PREFIX<br>TAG                                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                           |
| {0 950}                                                  | Continued From page 20<br><br>representative.<br><br>This MN Requirement is not met as evidenced<br>by:<br>No further action required                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | {0 950}                                                                                |                                                                                                                          |  |                                                                    |
| {0 970}<br>SS=C                                          | <b>144G.50 Subd. 5</b> Waivers of liability prohibited<br><br>The contract must not include a waiver of facility<br>liability for the health and safety or personal<br>property of a resident. The contract must not<br>include any provision that the facility knows or<br>should know to be deceptive, unlawful, or<br>unenforceable under state or federal law, nor<br>include any provision that requires or implies a<br>lesser standard of care or responsibility than is<br>required by law.<br><br>This MN Requirement is not met as evidenced<br>by:<br>No further action required                                                                                                                                                                                                               | {0 970}                                                                                |                                                                                                                          |  |                                                                    |
| {01500}<br>SS=F                                          | <b>144G.63 Subd. 5</b> Required annual training<br><br>(a) All staff that perform direct services must<br>complete at least eight hours of annual training<br>for each 12 months of employment. The training<br>may be obtained from the facility or another<br>source and must include topics relevant to the<br>provision of assisted living services. The annual<br>training must include:<br>(1) training on reporting of maltreatment of<br>vulnerable adults under section 626.557;<br>(2) review of the assisted living bill of rights and<br>staff responsibilities related to ensuring the<br>exercise and protection of those rights;<br>(3) review of infection control techniques used in<br>the home and implementation of infection control<br>standards including a review of hand washing | {01500}                                                                                |                                                                                                                          |  |                                                                    |



Minnesota Department of Health

|                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                |                                                                                                                          |  |                                                   |
|---------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>34822                | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br>R<br>10/02/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>HARDING PLACE |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | STREET ADDRESS, CITY, STATE, ZIP CODE<br>24448 296TH AVENUE<br>PIERZ, MN 56364 |                                                                                                                          |  |                                                   |
| (X4) ID<br>PREFIX<br>TAG                          | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                          |
| {01500}                                           | Continued From page 21<br><br>techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases;<br>(4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders;<br>(5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and<br>(6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person.<br>(b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics:<br>(1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication;<br>(2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or<br>(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 | {01500}                                                                        |                                                                                                                          |  |                                                   |



Minnesota Department of Health

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                        |                                                                                                                          |  |                                                                    |
|----------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34822</b>              | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>10/02/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HARDING PLACE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>24448 296TH AVENUE<br/>PIERZ, MN 56364</b> |                                                                                                                          |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ID<br>PREFIX<br>TAG                                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                           |
| {01500}                                                  | Continued From page 22<br><br>access in real time, and closed captions.<br><br>This MN Requirement is not met as evidenced<br>by:<br>No further action required                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | {01500}                                                                                |                                                                                                                          |  |                                                                    |
| {01530}<br>SS=D                                          | <b>144G.64 TRAINING IN DEMENTIA CARE<br/>REQUIRED</b><br><br>(a) All assisted living facilities must meet the<br>following training requirements:<br>(1) supervisors of direct-care staff must have at<br>least eight hours of initial training on topics<br>specified under paragraph (b) within 120 working<br>hours of the employment start date, and must<br>have at least two hours of training on topics<br>related to dementia care for each 12 months of<br>employment thereafter;<br>(2) direct-care employees must have completed<br>at least eight hours of initial training on topics<br>specified under paragraph (b) within 160 working<br>hours of the employment start date. Until this<br>initial training is complete, an employee must not<br>provide direct care unless there is another<br>employee on site who has completed the initial<br>eight hours of training on topics related to<br>dementia care and who can act as a resource<br>and assist if issues arise. A trainer of the<br>requirements under paragraph (b) or a supervisor<br>meeting the requirements in clause (1) must be<br>available for consultation with the new employee<br>until the training requirement is complete.<br>Direct-care employees must have at least two<br>hours of training on topics related to dementia for<br>each 12 months of employment thereafter;<br><br>This MN Requirement is not met as evidenced<br>by:<br>No further action required | {01530}                                                                                |                                                                                                                          |  |                                                                    |



Minnesota Department of Health

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                        |                                                                                                                          |  |                                                                    |
|----------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34822</b>              | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>10/02/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HARDING PLACE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>24448 296TH AVENUE<br/>PIERZ, MN 56364</b> |                                                                                                                          |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ID<br>PREFIX<br>TAG                                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                           |
| {01910}<br>SS=D                                          | <b>144G.71 Subd. 22 Disposition of medications</b><br><br>(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.<br>(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 medications and controlled substances.<br>(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.<br><br>This MN Requirement is not met as evidenced by:<br>No further action required | {01910}                                                                                |                                                                                                                          |  |                                                                    |
| {02320}<br>SS=D                                          | <b>144G.91 Subd. 4 (b) Appropriate care and services</b><br><br>(b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan.<br><br>This MN Requirement is not met as evidenced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | {02320}                                                                                |                                                                                                                          |  |                                                                    |



Minnesota Department of Health

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                        |                                                                                                                          |  |                                                                    |
|----------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34822</b>              | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>10/02/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HARDING PLACE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>24448 296TH AVENUE<br/>PIERZ, MN 56364</b> |                                                                                                                          |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                      | ID<br>PREFIX<br>TAG                                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                           |
| {02320}                                                  | Continued From page 24<br><br>by:<br>No further action required                                                                                                                                                                                                                                                                                                                                                                                                                   | {02320}                                                                                |                                                                                                                          |  |                                                                    |
| {02420}<br>SS=F                                          | 144G.91 Subd. 14 Communication privacy<br><br>(a) Residents have the right to communicate<br>privately with persons of their choice.<br>(b) If an assisted living facility is sending or<br>receiving mail on behalf of residents, the assisted<br>living facility must do so without interference.<br>(c) Residents must be provided access to a<br>telephone to make and receive calls.<br><br>This MN Requirement is not met as evidenced<br>by:<br>No further action required | {02420}                                                                                |                                                                                                                          |  |                                                                    |





*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically Delivered

July 30, 2024

Licensee  
Harding Place  
24448 296th Avenue  
Pierz, MN 56364

RE: Project Number(s) SL34822015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 11, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

### **STATE CORRECTION ORDERS**

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

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

### **DOCUMENTATION OF ACTION TO COMPLY**

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

The correction order documentation should include the following:

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



### **CORRECTION ORDER RECONSIDERATION PROCESS**

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

To submit a reconsideration request, please visit:

**<https://forms.web.health.state.mn.us/form/HRDAppealsForm>**

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **<https://forms.office.com/g/Bm5uQEPhVa>**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at [susan.winkelmann@state.mn.us](mailto: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,

A handwritten signature in black ink, appearing to read "Amy M. Hyers", with a long horizontal flourish extending to the right.

Amy Hyers, Supervisor

State Evaluation Team

Email: [amy.hyers@state.mn.us](mailto:amy.hyers@state.mn.us)

Telephone: 651-443-2878 Fax: 1-866-890-9290

HHH



Minnesota Department of Health

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                        |
|----------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34822</b>              | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>07/11/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HARDING PLACE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>24448 296TH AVENUE<br/>PIERZ, MN 56364</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ID<br>PREFIX<br>TAG                                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | (X5)<br>COMPLETE<br>DATE                               |
| 0 000                                                    | <p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>ASSISTED LIVING PROVIDER LICENSING<br/>CORRECTION ORDER(S)</p> <p>In accordance with Minnesota Statutes, section<br/>144G.08 to 144G.95, these correction orders are<br/>issued pursuant to a survey.</p> <p>Determination of whether violations are corrected<br/>requires compliance with all requirements<br/>provided at the Statute number indicated below.<br/>When Minnesota Statute contains several items,<br/>failure to comply with any of the items will be<br/>considered lack of compliance.</p> <p>INITIAL COMMENTS:<br/>SL34822015-0</p> <p>On July 8, 2024, through July 11, 2024, the<br/>Minnesota Department of Health conducted a<br/>survey at the above provider, and the following<br/>correction orders are issued. At the time of the<br/>survey, there were 18 residents; 18 receiving<br/>services under the Assisted Living license.</p> | 0 000                                                                                  | <p>Minnesota Department of Health is<br/>documenting the State Licensing<br/>Correction Orders using federal software.<br/>Tag numbers have been assigned to<br/>Minnesota State Statutes for Assisted<br/>Living License Providers. The assigned<br/>tag number appears in the far-left column<br/>entitled "ID Prefix Tag." The state Statute<br/>number and the corresponding text of the<br/>state Statute out of compliance is listed in<br/>the "Summary Statement of Deficiencies"<br/>column. This column also includes the<br/>findings which are in violation of the state<br/>requirement after the statement, "This<br/>Minnesota requirement is not met as<br/>evidenced by." Following the surveyors'<br/>findings is the Time Period for Correction.</p> <p>PLEASE DISREGARD THE HEADING OF<br/>THE FOURTH COLUMN WHICH<br/>STATES,"PROVIDER'S PLAN OF<br/>CORRECTION." THIS APPLIES TO<br/>FEDERAL DEFICIENCIES ONLY. THIS<br/>WILL APPEAR ON EACH PAGE.</p> <p>THERE IS NO REQUIREMENT TO<br/>SUBMIT A PLAN OF CORRECTION FOR<br/>VIOLATIONS OF MINNESOTA STATE<br/>STATUTES.</p> <p>The letter in the left column is used for<br/>tracking purposes and reflects the scope<br/>and level issued pursuant to 144G.31<br/>subd. 1, 2, and 3.</p> |  |                                                        |
| 0 460<br>SS=F                                            | <p>144G.41 Subdivision 1 Minimum requirements</p> <p>(5) provide a means for residents to request<br/>assistance for health and safety needs 24 hours</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 0 460                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                        |

Minnesota Department of Health

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

TITLE

(X6) DATE



Minnesota Department of Health

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                        |                                                                                                                          |  |                                                     |
|----------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>34822</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>07/11/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HARDING PLACE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>24448 296TH AVENUE<br/>PIERZ, MN 56364</b>                                   |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 460                                                    | <p>Continued From page 1</p> <p>per day, seven days per week;<br/>(6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract;<br/>(7) permit residents access to food at any time;<br/>(8) allow residents to choose the resident's visitors and times of visits;<br/>(9) allow the resident the right to choose a roommate if sharing a unit;<br/>(10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living facility must not lock a resident in the resident's unit;</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on observation and interview, the licensee failed to provide a means for residents to request assistance for health and safety needs twenty-four hours a day, seven days a week. This had the potential to affect all residents.</p> <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 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).</p> <p>The findings include:</p> <p>On July 8, 2024, at approximately 10:30 a.m.,</p> | 0 460                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                        |                                                                                                                          |  |                                                     |
|----------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>34822</b>                 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>07/11/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HARDING PLACE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>24448 296TH AVENUE<br/>PIERZ, MN 56364</b> |                                                                                                                          |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ID<br>PREFIX<br>TAG                                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 460                                                    | <p>Continued From page 2</p> <p>during the entrance conference, licensed assisted living director (LALD)-A, stated the facility did not have a means for residents to call staff for assistance 24/7. LALD-A questioned if the requirement must still be met if the residents are independent. LALD-A stated the only place a call light is available to residents is in their shared restrooms.</p> <p>On July 9, 2024, at 12:35 p.m., LALD-A stated residents did not have access to a call system in their personal rooms or have the option to carry an alert system on their person. LALD-A stated someone that did not have their own phone would have to yell for help.</p> <p>On July 10, 2024, at approximately 1:10 p.m., licensed assisted living director in residency (LALDIR)-B stated if a resident fell in their room at night and needed help, the resident would have to wake up their neighbor unless a staff member could hear them yell.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days.</p> | 0 460                                                                                  |                                                                                                                          |  |                                                     |
| 0 470<br>SS=F                                            | <p><b>144G.41</b> Subdivision 1 Minimum requirements</p> <p>(11) develop and implement a staffing plan for determining its staffing level that:</p> <p>(i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility;</p> <p>(ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 0 470                                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                        |                                                                                                                          |  |                                                     |
|----------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>34822</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>07/11/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HARDING PLACE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>24448 296TH AVENUE<br/>PIERZ, MN 56364</b>                                   |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 470                                                    | <p>Continued From page 3</p> <p>on a 24-hour per day basis; and<br/>(iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility;<br/>(12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be:<br/>(i) awake;<br/>(ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time;<br/>(iii) capable of communicating with residents;<br/>(iv) capable of providing or summoning the appropriate assistance; and<br/>(v) capable of following directions;</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on observation, interview, and record review, the licensee failed to ensure the clinical nurse supervisor developed and implemented a written staffing plan or 24-hour staffing schedule per Minn. Rule 4659.0180 Subp. 3 and 4, or participated in review of the staffing plan two times annually to determine if staffing levels met the needs of all residents. Further, the licensee failed to ensure the daily staffing schedule with accurate information was posted for residents, staff, and visitors to review.</p> <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 was issued at a widespread scope (when</p> | 0 470                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                |                                                                                                                          |  |                                              |
|---------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>34822                | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br>07/11/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>HARDING PLACE |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | STREET ADDRESS, CITY, STATE, ZIP CODE<br>24448 296TH AVENUE<br>PIERZ, MN 56364 |                                                                                                                          |  |                                              |
| (X4) ID<br>PREFIX<br>TAG                          | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                     |
| 0 470                                             | <p>Continued From page 4</p> <p>problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>On July 8, 2024, at approximately 10:40 a.m., during the entrance conference, clinical nurse supervisor (CNS)-D stated they were the only registered nurse employed for the licensee's location, they were responsible for covering two locations, and they were not on-site at the licensee's location five days per week. CNS-D stated the licensee scheduled two unlicensed personnel (ULP) daily for the day shift, one ULP for the evening shift with an occasional additional staff member "if it gets picked up" for a short shift in the evening, and one ULP on the overnight shift.</p> <p>On July 9, 2024, at approximately 12:20 p.m., the surveyor observed a single sheet of paper on a centrally located bulletin board titled Assisted Living Staffing For [licensee name]. The form indicated the dates of July 8, 2024, to July 14, 2024, and contained numbers of certain categories of staff who would be working each shift. For AM shift, the form indicated one registered nurse (RN), one licensed practical nurse (LPN), three resident caregivers (RCG), and one on-call RN. For PM shift, the form indicated three RCG and one on-call RN. For the overnight (NOC) shift, the form indicated two RCG, one RCG "Sleeper", and one on-call RN.</p> <p>On July 9, 2024, at approximately 12:20 p.m., licensed assisted living director (LALD)-A stated the licensee's new licensed assisted living director in residency (LALDIR) was responsible for posting the daily work schedule. LALD-A</p> | 0 470                                                                          |                                                                                                                          |  |                                              |



Minnesota Department of Health

|                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                |                                                                                                                          |  |                                              |
|---------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>34822                | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br>07/11/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>HARDING PLACE |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | STREET ADDRESS, CITY, STATE, ZIP CODE<br>24448 296TH AVENUE<br>PIERZ, MN 56364 |                                                                                                                          |  |                                              |
| (X4) ID<br>PREFIX<br>TAG                          | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                     |
| 0 470                                             | <p>Continued From page 5</p> <p>agreed the staffing pattern on the posted schedule was incorrect and stated it may have been incorrectly stored on the company's SharePoint site.</p> <p>On July 10, 2024, at approximately 9:40 a.m., clinical nurse supervisor (CNS)-D stated the staffing plan was based off resident case mix and that was driven by the nursing assessment, which was their only involvement.</p> <p>On July 10, 2024, at approximately 1:10 p.m., when the surveyor asked how the staffing plan was developed, LALDIR-B stated they started with the licensee approximately five to six months ago, and they "inherited" it. LALDIR-B stated there had been no formal review of the staffing plan since their hire, although they had discussed the need for more staff during face-to-face discussions with CNS-D. LALDIR-B stated at some point there had been a reduction in scheduled caregivers due to a drop in census, which at that time, the licensee made the second RCG shift during the evening shift "voluntary". LALDIR-B stated they had hit a "corporate roadblock" on scheduling additional staff members due to the current census. LALDIR-B stated corporate personnel had indicated the licensee could hire as many casual personnel as they desired but "we can't force them to pick up shifts." LALDIR-B stated CNS-D had not been involved in any formal review of the staffing plan. LALDIR-B stated they were not familiar with the staffing plan requirements and was not familiar with how to locate Minnesota Assisted Living Statutes or Rules.</p> <p>Licensee's Staffing and Scheduling policy last revised August 1, 2021, indicated the clinical nurse supervisor will develop and implement a</p> | 0 470                                                                          |                                                                                                                          |  |                                              |



Minnesota Department of Health

|                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                |                                                                                                                          |  |                                              |
|---------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>34822                | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br>07/11/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>HARDING PLACE |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | STREET ADDRESS, CITY, STATE, ZIP CODE<br>24448 296TH AVENUE<br>PIERZ, MN 56364 |                                                                                                                          |  |                                              |
| (X4) ID<br>PREFIX<br>TAG                          | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                     |
| 0 470                                             | <p>Continued From page 6</p> <p>written staffing plan that provides an adequate number of qualified direct-care staff to meet the residents' needs 24-hours a day, seven-days a week. The clinical nurse supervisor must ensure that staffing levels are adequate to address the following:</p> <p>a. Each resident's needs, as identified in the resident's service plan and assisted living contract;</p> <p>b. Each resident's acuity level, as determined by the most recent assessment or individualized review;</p> <p>c. The ability of staff to timely meet the resident's scheduled and reasonable foreseeable unscheduled needs given the physical layout of the facility premises;</p> <p>d. Whether the facility has a secured dementia care unit; and</p> <p>e. Staff experience, training, and competency. In addition, the policy indicated the clinical nurse supervisor will develop a 24-hour daily staffing schedule that will identify:</p> <p>a. direct-care staff work schedules for each direct-care staff member showing all work shifts, including days and hours worked; and</p> <p>b. the direct-care staff member's resident assignments or work location.</p> <p>The policy further indicated the clinical nurse supervisor will base site case mix letters/tiers on individualized needs by assessment in the rate determination tool and each letter/tier was attached to approximate staffing hours. Staffing floor hours are spread through the site as resident need patterns arise and patterns were to be determined by the site director, clinical nurse, and licensed practical nurse (if applicable).</p> <p>No further information was provided.</p> | 0 470                                                                          |                                                                                                                          |  |                                              |



Minnesota Department of Health

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                        |                                                                                                                          |  |                                                        |
|----------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34822</b>              | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>07/11/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HARDING PLACE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>24448 296TH AVENUE<br/>PIERZ, MN 56364</b> |                                                                                                                          |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | ID<br>PREFIX<br>TAG                                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| 0 470                                                    | Continued From page 7                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 0 470                                                                                  |                                                                                                                          |  |                                                        |
| 0 480<br>SS=F                                            | <p>144G.41 Subd 1 (13) (i) (B) Minimum requirements</p> <p>(13) offer to provide or make available at least the following services to residents:<br/>(B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code.</p> <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) 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).</p> <p>The findings include:</p> <p>Please refer to the included document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated July 8, 2024, for the specific Minnesota Food Code deficiencies. The inspection report was provided to the licensee within 24 hours of the inspection.</p> <p>TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.</p> | 0 480                                                                                  |                                                                                                                          |  |                                                        |



Minnesota Department of Health

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                        |                                                                                                                          |  |                                                        |
|----------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34822</b>              | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>07/11/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HARDING PLACE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>24448 296TH AVENUE<br/>PIERZ, MN 56364</b> |                                                                                                                          |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ID<br>PREFIX<br>TAG                                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| 0 640<br>SS=F                                            | <p><b>144G.42 Subd. 7</b> Posting information for reporting suspected c</p> <p>The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by:</p> <p>(1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility;</p> <p>(2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and</p> <p>(3) providing reasonable accommodations with information and notices in plain language.</p> <p>This MN Requirement is not met as evidenced by:</p> <p>Based on observation and interview, the licensee failed to support protection and safety when they did not post phone numbers for reporting to the Minnesota Adult Abuse Reporting Center (MAARC) and failed to post the 911 emergency number in common areas and near telephones provided by the assisted living facility. This had the potential to affect all residents, staff and visitors.</p> <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 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).</p> <p>The findings include:</p> | 0 640                                                                                  |                                                                                                                          |  |                                                        |



Minnesota Department of Health

|                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                |                                                                                                                          |  |                                              |
|---------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>34822                | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br>07/11/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>HARDING PLACE |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br>24448 296TH AVENUE<br>PIERZ, MN 56364 |                                                                                                                          |  |                                              |
| (X4) ID<br>PREFIX<br>TAG                          | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                     |
| 0 640                                             | <p>Continued From page 9</p> <p>On July 9, 2024, at approximately 12:20 p.m., the surveyor observed the facility's main entry area and common areas lacked the required posted information as follows:</p> <ul style="list-style-type: none"><li>- posting of 911 emergency number in common areas and near telephones provided by the Assisted Living facility; and</li><li>- posting of information and the reporting number for the MAARC to report suspected maltreatment of a vulnerable adult under section 626.557.</li></ul> <p>In addition, the surveyor observed a landline telephone phone on the kitchen countertop near a resident common area. Unlicensed personnel (ULP)-E stated it was a shared phone utilized by the residents. The required postings were not present.</p> <p>On July 9, 2024, at approximately 12:20 p.m., licensed assisted living director (LALD)-A viewed the bulletin board in the main entry area and stated she was unable to locate the information. LALD-A and ULP-E both stated the 911 number was also not posted near the common use phone.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days.</p> | 0 640                                                                          |                                                                                                                          |  |                                              |
| 0 650<br>SS=F                                     | <p>144G.42 Subd. 8 Employee records</p> <p>(a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information:</p> <p>(1) evidence of current professional licensure, registration, or certification if licensure,</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 0 650                                                                          |                                                                                                                          |  |                                              |



Minnesota Department of Health

|                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                |                                                                                                                          |  |                                              |
|---------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>34822                | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br>07/11/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>HARDING PLACE |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | STREET ADDRESS, CITY, STATE, ZIP CODE<br>24448 296TH AVENUE<br>PIERZ, MN 56364 |                                                                                                                          |  |                                              |
| (X4) ID<br>PREFIX<br>TAG                          | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                     |
| 0 650                                             | <p>Continued From page 10</p> <p>registration, or certification is required by this chapter or rules;</p> <p>(2) records of orientation, required annual training and infection control training, and competency evaluations;</p> <p>(3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision;</p> <p>(4) documentation of annual performance reviews that identify areas of improvement needed and training needs;</p> <p>(5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and</p> <p>(6) documentation of the background study as required under section 144.057.</p> <p>This MN Requirement is not met as evidenced by:</p> <p>Based on observation, interview, and record review, the licensee failed to ensure employee records included all required content for two of two employees (unlicensed personnel (ULP)-E, ULP-F).</p> <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 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).</p> <p>The findings include:</p> <p>ULP-E<br/>ULP-E was hired December 10, 2008, to perform</p> | 0 650                                                                          |                                                                                                                          |  |                                              |



Minnesota Department of Health

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                        |                                                                                                                          |  |                                                        |
|----------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34822</b>              | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>07/11/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HARDING PLACE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>24448 296TH AVENUE<br/>PIERZ, MN 56364</b> |                                                                                                                          |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ID<br>PREFIX<br>TAG                                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| 0 650                                                    | <p>Continued From page 11</p> <p>direct care services for residents of the licensee.</p> <p>On July 9, 2024, at approximately 7:30 a.m., the surveyor observed ULP-E assist multiple residents with treatment and medication administration services.</p> <p>On July 9, 2024, at 10:05 a.m., the surveyor observed ULP-E assist R2 to drain their catheter.</p> <p>R2's June 2024 Service Recap Summary indicated ULP-E performed the following services for R2 during the month of June: bathing, vital signs, catheter care and recording of output, dressing, grooming, support stockings, and medication administration.</p> <p>ULP-E's employee record lacked evidence of orientation/training and/or competencies for the following:<br/>Orientation/Trainings-</p> <ul style="list-style-type: none"><li>- Review of provider's policies and procedures;</li><li>- Handling of resident complaints, reporting of complaints, where to report;</li><li>- Consumer advocacy services;</li><li>- Review of types of Assisted Living services the employee will provide and provider's scope of license;</li><li>- Orientation to each specific resident and services provided;</li><li>- Medication administration;</li><li>- Treatment administration; and</li><li>- Other specified delegated tasks (catheter care).</li></ul> <p>Competencies-</p> <ul style="list-style-type: none"><li>- Appropriate and safe techniques in personal hygiene and grooming including:<ul style="list-style-type: none"><li>- hair care and bathing;</li><li>- care of teeth, gums, and oral prosthetic devices;</li></ul></li></ul> | 0 650                                                                                  |                                                                                                                          |  |                                                        |



Minnesota Department of Health

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                        |                                                                                                                          |  |                                                     |
|----------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>34822</b>                 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>07/11/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HARDING PLACE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>24448 296TH AVENUE<br/>PIERZ, MN 56364</b> |                                                                                                                          |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ID<br>PREFIX<br>TAG                                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 650                                                    | <p>Continued From page 12</p> <ul style="list-style-type: none"><li>- care and use of hearing aides;</li><li>- dressing and assisting with toileting;</li><li>- Standby assistance techniques and how to perform them;</li><li>- Safe transfer techniques and ambulation;</li><li>- Range of motioning and positioning;</li><li>- Treatment administration (blood glucometers, compression stockings); and</li><li>- Other specified delegated tasks (catheter care).</li></ul> <p>ULP-F<br/>ULP-F was hired June 19, 2017, to perform direct care services for residents of the licensee.</p> <p>R2's June 2024 Service Recap Summary indicated ULP-F performed the following services for R2 during the month of June: catheter care and recording of output, dressing, grooming, support stockings, and medication administration.</p> <p>On July 9, 2024, at approximately 2:00 p.m., the surveyor observed ULP-F arrive to the facility, count the controlled medications with ULP-E, and begin working with residents of the facility.</p> <p>ULP-F's employee record lacked evidence of orientation/training and/or competencies for the following:<br/>Orientation/Trainings-</p> <ul style="list-style-type: none"><li>- Review of provider's policies and procedures;</li><li>- Handling of resident complaints, reporting of complaints, where to report;</li><li>- Consumer advocacy services;</li><li>- Review of types of Assisted Living services the employee will provide and provider's scope of license; and</li><li>- Orientation to each specific resident and services provided.</li></ul> <p>Competencies-</p> | 0 650                                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                        |                                                                                                                          |  |                                                     |
|----------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>34822</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>07/11/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HARDING PLACE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>24448 296TH AVENUE<br/>PIERZ, MN 56364</b>                                   |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 650                                                    | <p>Continued From page 13</p> <ul style="list-style-type: none"><li>- Appropriate and safe techniques in personal hygiene and grooming including:<ul style="list-style-type: none"><li>- hair care and bathing;</li><li>- care of teeth, gums, and oral prosthetic devices;</li><li>- care and use of hearing aides;</li><li>- dressing and assisting with toileting;</li></ul></li><li>- Standby assistance techniques and how to perform them;</li><li>- Safe transfer techniques and ambulation;</li><li>- Range of motioning and positioning;</li><li>- Medication administration;</li><li>- Treatment administration (blood glucometers, compression stockings); and</li><li>- Other specified delegated tasks (catheter care).</li></ul> <p>On July 9, 2024, at 9:42 a.m., licensed assisted living director in residency (LALDIR)-B stated they had provided all training and competency records for ULP-E. LALDIR-B stated due to the record keeping of previous management, they were unable to locate any additional records.</p> <p>On July 9, 2024, at 9:48 a.m., ULP-E stated they were trained many years ago by nurses who previously worked for the licensee. ULP-E stated they recalled the nurses going over procedures including right route, right time, right person, etc., and stated they had to be signed off by a nurse to be able to pass medications.</p> <p>On July 9, 2024, at 9:54 a.m., clinical nurse supervisor (CNS)-D stated they had worked for the licensee for approximately three months and had done no competency evaluations with ULP-E or ULP-F.</p> <p>On July 9, 2024, at approximately 12:45 p.m., licensed assisted living director (LALD)-A stated ULP-F's records, along with most if not all of their</p> | 0 650                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                |                                                                                                                          |  |                                              |
|---------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>34822                | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br>07/11/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>HARDING PLACE |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>24448 296TH AVENUE<br>PIERZ, MN 56364 |                                                                                                                          |  |                                              |
| (X4) ID<br>PREFIX<br>TAG                          | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                     |
| 0 650                                             | Continued From page 14<br><br>other ULP did not contain evidence of the initial orientation requirements for 144G. LALD-A stated the licensee had just began auditing staff's records to determine what was missing.<br><br>On July 9, 2024, at 2:23 p.m., ULP-F stated they recalled attending a classroom training at another of the licensee's locations for their general orientation. ULP-F stated they were trained by a nurse and demonstrated competency to a nurse for medications, treatments, and delegated tasks and did not know why there was no record of it.<br><br>Licensee's policy titled 10.04 Competency Training Evaluations dated as revised August 1, 2021, indicated a copy of all education, training, and competency testing shall be kept in each team member's personnel file.<br><br>No further information was received.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 0 650                                                                          |                                                                                                                          |  |                                              |
| 0 660<br>SS=F                                     | 144G.42 Subd. 9 Tuberculosis prevention and control<br><br>(a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide                                                                                                                                                                                                                                                                                  | 0 660                                                                          |                                                                                                                          |  |                                              |



Minnesota Department of Health

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                        |                                                                                                                          |  |                                                        |
|----------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34822</b>              | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>07/11/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HARDING PLACE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>24448 296TH AVENUE<br/>PIERZ, MN 56364</b> |                                                                                                                          |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ID<br>PREFIX<br>TAG                                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| 0 660                                                    | <p>Continued From page 15</p> <p>technical assistance regarding implementation of the guidelines.<br/>(b) The facility must maintain written evidence of compliance with this subdivision.</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included baseline testing and screening and annual training for two of two employees (unlicensed personnel (ULP)-E and ULP-F).</p> <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) 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).</p> <p>The findings include:</p> <p>The licensee's Facility TB Risk Assessment dated as last completed July 18, 2023, indicated the facility's risk level was low for TB transmission.</p> <p>ULP-E<br/>ULP-E was hired December 10, 2008.</p> <p>ULP-E's position description signed by ULP-E on May 22, 2021, indicated ULP-E's job summary was to ensure quality and safe delivery of care to the residents including personal cares and socialization.</p> | 0 660                                                                                  |                                                                                                                          |  |                                                        |



Minnesota Department of Health

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                        |                                                                                                                          |  |                                                     |
|----------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>34822</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>07/11/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HARDING PLACE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>24448 296TH AVENUE<br/>PIERZ, MN 56364</b>                                   |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 660                                                    | <p>Continued From page 16</p> <p>ULP-E's employee record lacked a TB symptom screen and TB risk history questionnaire, TB test (either a two-step TST or a TB blood test/IGRA) and lacked any evidence of TB training.</p> <p>On June 9, 2024, at approximately 7:30 a.m., the surveyor observed ULP-E providing medication administration services to multiple residents.</p> <p>ULP-E's employee record lacked evidence of a baseline screening for TB, evidence of a two-step Mantoux or other acceptable substitute, and lacked evidence of any TB training.</p> <p>ULP-F<br/>ULP-F was hired June 19, 2017.</p> <p>ULP-F's position description signed by ULP-F on May 19, 2021, indicated ULP-F's job summary was to ensure quality and safe delivery of care to the residents including personal cares and socialization.</p> <p>ULP-F's employee record lacked a TB symptom screen and TB risk history questionnaire, TB test (either a two-step TST or a TB blood test/IGRA) and lacked any evidence of TB training.</p> <p>On July 9, 2024, at 12:49 p.m., licensed assisted living director (LALD)-A stated neither ULP-E nor ULP-F had any documentation in their employee records related to tuberculosis including a baseline screening tool, a two-step Mantoux, or evidence of tuberculosis training. LALD-A stated they did not know what happened to the previous employee files for some of the long-term staff.</p> <p>On July 9, 2024, at 1:08 p.m., licensed assisted living director in residency (LALDIR)-B stated ULP-E and ULP-F were two of approximately five</p> | 0 660                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                        |                                                                                                                          |  |                                                     |
|----------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>34822</b>                 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>07/11/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HARDING PLACE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>24448 296TH AVENUE<br/>PIERZ, MN 56364</b> |                                                                                                                          |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ID<br>PREFIX<br>TAG                                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 660                                                    | <p>Continued From page 17</p> <p>total staff that had nothing in their employee files related to tuberculosis screening, testing, or training. LALDIR-B stated a couple of weeks ago there was a director's meeting in the corporate office where this was discussed which prompted internal auditing.</p> <p>On July 9, 2024, at approximately 2:00 p.m., the surveyor observed ULP-F arrive to the facility, count the controlled medications with ULP-E, and begin working with residents of the facility.</p> <p>The licensee's Infection Control policy titled 8.07 Tuberculosis &amp; Staff Screenings, last revised June 17, 2022, indicated all assisted living personnel whose essential job functions require work within the same air space as residents shall be screened and tested for tuberculosis. The site shall have an ongoing program for screening and educating personnel on tuberculosis and have an infection control plan for handling persons with active tuberculosis. The policy indicated baseline screening was required for all personnel through use of a Baseline TB Screening Tool for HCWs (health care workers), a two-step Mantoux conducted with results documented.</p> <p>The Centers for Disease Control and Prevention's webpage titled Tuberculosis Screening, Testing, and Treatment of U.S. Health Care Personnel: Recommendations from the National Tuberculosis Controllers Association and CDC, 2019, indicated all healthcare personnel should have a TB screening with an individual risk assessment and symptom evaluation at baseline (preplacement); TB testing with an interferon-gamma release assay (IGRA) or a tuberculin skin test (TST) for persons without documented prior TB disease or latent TB infection (LTBI); and annual TB education of all</p> | 0 660                                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                        |                                                                                                                          |  |                                                     |
|----------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>34822</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>07/11/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HARDING PLACE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>24448 296TH AVENUE<br/>PIERZ, MN 56364</b>                                   |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 660                                                    | Continued From page 18<br><br>health care personnel.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one<br>(21) days.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 0 660                                                                  |                                                                                                                          |  |                                                     |
| 0 680<br>SS=F                                            | 144G.42 Subd. 10 Disaster planning and<br>emergency preparedness<br><br>(a) The facility must meet the following<br>requirements:<br>(1) have a written emergency disaster plan that<br>contains a plan for evacuation, addresses<br>elements of sheltering in place, identifies<br>temporary relocation sites, and details staff<br>assignments in the event of a disaster or an<br>emergency;<br>(2) post an emergency disaster plan prominently;<br>(3) provide building emergency exit diagrams to<br>all residents;<br>(4) post emergency exit diagrams on each floor;<br>and<br>(5) have a written policy and procedure regarding<br>missing residents.<br>(b) The facility must provide emergency and<br>disaster training to all staff during the initial staff<br>orientation and annually thereafter and must<br>make emergency and disaster training annually<br>available to all residents. Staff who have not<br>received emergency and disaster training are<br>allowed to work only when trained staff are also<br>working on site.<br>(c) The facility must meet any additional<br>requirements adopted in rule.<br><br>This MN Requirement is not met as evidenced<br>by:<br>Based on observation, interview, and record | 0 680                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                        |                                                                                                                          |  |                                                        |
|----------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34822</b>              | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>07/11/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HARDING PLACE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>24448 296TH AVENUE<br/>PIERZ, MN 56364</b> |                                                                                                                          |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ID<br>PREFIX<br>TAG                                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| 0 680                                                    | <p>Continued From page 19</p> <p>review, the licensee failed to post an emergency disaster plan with the required updated content prominently, and failed to review the required content annually. This had the potential to affect all residents, staff, and visitors.</p> <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 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).</p> <p>The findings include:</p> <p>On July 8, 2024, at 1:36 p.m., unlicensed personnel (ULP)-E stated the licensee's full emergency preparedness plan (EPP) binder was housed in the facility office which was locked when management staff were not present. ULP-E stated although they have a key to the office, the binder would not be readily accessible for anyone to obtain in an emergency.</p> <p>The licensee's EPP binder contained a facility Hazard Vulnerability Assessment (HVA) dated, June 21, 2023.</p> <p>On July 9, 2024, at approximately 12:20 p.m., during a review of the licensee's centrally located bulletin board, the surveyor observed a clear page protector tacked to the bulletin board which contained the following policies:<br/>4.10 Organization Information for [licensee name], updated May 19, 2023. One of one page. Policy 4.10 contained the name and contact information for the facility's previous director.</p> | 0 680                                                                                  |                                                                                                                          |  |                                                        |



Minnesota Department of Health

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                        |                                                                                                                          |  |                                                     |
|----------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>34822</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>07/11/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HARDING PLACE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>24448 296TH AVENUE<br/>PIERZ, MN 56364</b>                                   |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 680                                                    | <p>Continued From page 20</p> <p>4.11 Authorities and References [licensee name], updated May 19, 2023. Three of three pages. Policy 4.11 contained the name and contact information for the facility's previous director.</p> <p>4.17 Transportation and Evacuation Locations - Site, updated June 20, 2023. Two of two pages.</p> <p>4.23 Emergency Call List, updated June 18, 2022. One of two pages. Policy 4.23 contained the name and contact information for the facility's previous director and did not include information for the facility's clinical nurse supervisor.</p> <p>4.66 Procurement of Subsistence Needs HH-Pierz, updated May 19, 2023. One of one page.</p> <p>4.71 Fire &amp; Evacuation Plan, updated May 19, 2023. Ten pages plus five pages of floor plans with exit maps.</p> <p>On July 9, 2024, at 12:30 p.m., licensed assisted living director (LALD)-A stated the licensee's management company reviews the emergency disaster plan annually but verified the licensee's HVA review was overdue. LALD-A stated the management company generally did not update the date on a policy unless a change was made to the policy but added they did not know how the management company tracked or documented the due date of the annual review.</p> <p>Minnesota Administrative Rule 4659.0100 dated August 11, 2021, indicated assisted living facilities shall comply with the federal emergency preparedness regulations for long-term care facilities under Code of Federal Regulations, title 42, section 483.73, or successor requirements. This part references documents, specifications, methods, and standards in "State Operations Manual Appendix Z - Emergency Preparedness for All Provider and Certified Supplier Types: Interpretive Guidance."</p> | 0 680                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                 |                                                                                                                          |  |                                              |
|---------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>34822 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br>07/11/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>HARDING PLACE |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br>24448 296TH AVENUE<br>PIERZ, MN 56364                                           |  |                                              |
| (X4) ID<br>PREFIX<br>TAG                          | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ID<br>PREFIX<br>TAG                                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                     |
| 0 680                                             | Continued From page 21<br><br>Licensee policy 4.95 Annual Review Checklist last revised June 10, 2022, indicated the following policies must be reviewed and updated annually:<br>4.02 Hazard Vulnerability Analysis (HVA)<br>4.10 Organization Information<br>4.11 Authorities and References<br>4.17 Transportation and Evacuation<br>4.23 Emergency Call List<br>4.66 Procurement of Subsistence Needs<br>4.71 Fire & Evacuation Plan<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days.                                                                                                                                                                                                                                                                                                                   | 0 680                                                           |                                                                                                                          |  |                                              |
| 0 730<br>SS=F                                     | 144G.43 Subd. 3 Contents of resident record<br><br>Contents of a resident record include the following for each resident:<br>(1) identifying information, including the resident's name, date of birth, address, and telephone number;<br>(2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative;<br>(3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known;<br>(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;<br>(5) the resident's advance directives, if any;<br>(6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; | 0 730                                                           |                                                                                                                          |  |                                              |



Minnesota Department of Health

|                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                |                                                                                                                          |  |                                              |
|---------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>34822                | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br>07/11/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>HARDING PLACE |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br>24448 296TH AVENUE<br>PIERZ, MN 56364 |                                                                                                                          |  |                                              |
| (X4) ID<br>PREFIX<br>TAG                          | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                     |
| 0 730                                             | <p>Continued From page 22</p> <p>(7) the facility's current and previous assessments and service plans;<br/>(8) all records of communications pertinent to the resident's services;<br/>(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;<br/>(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;<br/>(11) documentation that services have been provided as identified in the service plan;<br/>(12) documentation that the resident has received and reviewed the assisted living bill of rights;<br/>(13) documentation of complaints received and any resolution;<br/>(14) a discharge summary, including service termination notice and related documentation, when applicable; and<br/>(15) other documentation required under this chapter and relevant to the resident's services or status.</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on interview and record review, the licensee failed to ensure the resident record included documentation of all provided services for two of two residents (R2, R3).</p> <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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected</p> | 0 730                                                                          |                                                                                                                          |  |                                              |



Minnesota Department of Health

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                        |                                                                                                                          |  |                                                     |
|----------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>34822</b>                 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>07/11/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HARDING PLACE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>24448 296TH AVENUE<br/>PIERZ, MN 56364</b> |                                                                                                                          |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ID<br>PREFIX<br>TAG                                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 730                                                    | <p>Continued From page 23</p> <p>or has the potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>R2<br/>R2's signed Service Plan (Private) - Addendum to Contract dated September 26, 2022, indicated R2 received the following services: activities twice daily, bathing twice weekly, blood pressure check weekly, catheter care four times daily, catheter change monthly, dietary needs twice daily, dressing twice daily, grooming twice daily, housekeeping weekly, laundry twice weekly, linen change weekly, medication administration four times daily, medication set-up weekly, measurement of output six times daily, pulse check weekly, respiration check monthly, supervision of catheter care bi-weekly, support stockings twice daily, temperature check monthly, and wight check monthly.</p> <p>R2's record included document titled Service Recap Summary - Month dated June 2024, which indicated licensee's staff failed to document whether the services were provided as identified in the service plan for the following services on June 28, 2024: assist with meals, 6:00 a.m.; dietary needs, 6:00 a.m.; assist with meals, midday; percentage of meal eaten, midday; and output, 9:50 p.m.</p> <p>R2's record included document titled Service Recap Summary - Month dated July 2024, which indicated licensee's staff failed to document whether the services were provided as identified in the service plan for the following services:</p> <p>-July 5, 2024: activities, 6:00 a.m.; assist with meals, 6:00 a.m.; dietary needs, 6:00 a.m.;</p> | 0 730                                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                        |                                                                                                                          |  |                                                     |
|----------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>34822</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>07/11/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HARDING PLACE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>24448 296TH AVENUE<br/>PIERZ, MN 56364</b>                                   |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 730                                                    | <p>Continued From page 24</p> <p>percentage of meal eaten, 6:00 a.m.; medication administration, 6:00 a.m.; assist with meals, midday; percentage of meal eaten, midday; activities, PM; assist with meals, PM; percentage of meal eaten, PM; and medication administration, PM.</p> <p>-July 6, 2024: activities, 6:00 a.m.; assist with meals, 6:00 a.m.; dietary needs, 6:00 a.m.; percentage of meal eaten, 6:00 a.m.; medication administration, 6:00 a.m.; assist with meals, midday; percentage of meal eaten, midday; activities, PM; assist with meals, PM; dietary needs, PM; percentage of meal eaten, PM; and medication administration, PM.</p> <p>-July 7, 2024: assist with meals, PM; dietary needs, PM; percentage of meal eaten, PM; and medication administration, PM.</p> <p>R3<br/>R3's signed Service Plan (Waiver) - Addendum to Contract dated September 30, 2021, indicated R3 received the following services: activities twice daily, bathing twice weekly, blood glucose checks four times daily, blood pressure check weekly, cares assist twice daily, diabetic services three times daily, dietary needs twice daily, glucometer control testing weekly, housekeeping three days a week, laundry twice weekly, linen change weekly, medication administration six times daily, medication set-up weekly, nail care weekly, recording of meals three times daily, pulse check weekly, respiration check monthly, special nursing task weekly, supervision of blood glucose monitoring bi-monthly, temperature check monthly, weight check monthly.</p> <p>R3's record included document titled Service Recap Summary - Month dated June 2024, which</p> | 0 730                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                        |                                                                                                                          |  |                                                        |
|----------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34822</b>              | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>07/11/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HARDING PLACE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>24448 296TH AVENUE<br/>PIERZ, MN 56364</b> |                                                                                                                          |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | ID<br>PREFIX<br>TAG                                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| 0 730                                                    | <p>Continued From page 25</p> <p>indicated licensee's staff failed to document whether the services were provided as identified in the service plan for the following services on:</p> <p>-June 18, 2024: nail care (Tu); 6:00 a.m.</p> <p>-June 21, 2024; blood glucose monitor, 4:30 p.m.; medication administration, 4:30 p.m.; percentage of meal eaten, 5:00 p.m.; activities, PM; diabetic, PM; dietary needs, PM; dressing, PM; blood glucose monitor, 8:00 p.m.; medication administration, 8:00 p.m.; diabetic, overnight, and dietary needs (Mo, Th, Fr), overnight.</p> <p>-June 22, 2024: activities, 6:00 a.m.; bathing (Tu, Sa), 6:00 a.m.; diabetic, 6:00 a.m.; dietary needs, 6:00 a.m.; dressing, 6:00 a.m.; laundry package (Tu, Sa), 6:00 a.m.; blood glucose monitor, 7:30 a.m.; medication administration, 7:30 a.m.; medication administration, 8:00 a.m.; percentage of meal eaten, 8:00 a.m.; blood glucose monitor, 11:30 a.m.; medication administration, 11:30 a.m.; percentage of meal eaten, 12:00 p.m.; medication administration, 4:00 p.m.; blood glucose monitor, 4:30 p.m.; medication administration, 4:30 p.m.; percentage of meal eaten, 5:00 p.m.; activities, PM; diabetic, PM; dietary needs, PM; dressing, PM; blood glucose monitor, 8:00 p.m.; medication administration, 8:00 p.m.; and diabetic, overnight.</p> <p>-June 23, 2024; activities, 6:00 a.m.; diabetic, 6:00 a.m.; dietary needs, 6:00 a.m.; dressing, 6:00 a.m.; housekeeping (We, Fr, Su), 6:00 a.m.; blood glucose monitor, 7:30 a.m.; medication administration, 7:30 a.m.; percentage of meal eaten, 8:00 a.m.; medication administration, 8:00 a.m.; activities, PM; and dietary needs, PM.</p> <p>-June 28, 2024: dietary needs, 6:00 a.m.</p> | 0 730                                                                                  |                                                                                                                          |  |                                                        |



Minnesota Department of Health

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                        |                                                                                                                          |  |                                                        |
|----------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34822</b>              | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>07/11/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HARDING PLACE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>24448 296TH AVENUE<br/>PIERZ, MN 56364</b> |                                                                                                                          |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ID<br>PREFIX<br>TAG                                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| 0 730                                                    | <p>Continued From page 26</p> <p>R3's record included document titled Service Recap Summary - Month dated July 2024, which indicated licensee's staff failed to document whether the services were provided as identified in the service plan for the following services on:</p> <p>-July 3, 2024: medication administration, 4:00 p.m.; blood glucose monitor, 4:30 p.m.; medication administration, 4:30 p.m.; percentage of meal eaten, 5:00 p.m.; activities, PM; diabetic, PM; dietary needs, PM; dressing, PM; blood glucose monitor, 8:00 p.m.; medication administration, 8:00 p.m.; and diabetic, overnight.</p> <p>-July 4, 2024: activities, 6:00 a.m.; diabetic, 6:00 a.m.; dietary needs, 6:00 a.m.; dressing, 6:00 a.m.; blood glucose monitor, 7:30 a.m.; medication administration, 7:30 a.m.; medication administration, 8:00 a.m.; percentage of meal eaten, 8:00 a.m.; blood glucose monitor, 11:30 a.m.; medication administration, 11:30 a.m.; percentage of meal eaten, 12:00 p.m.; medication administration, 4:00 p.m.; blood glucose monitor, 4:30 p.m.; medication administration, 4:30 p.m.; percentage of meal eaten, 5:00 p.m.; activities, PM; diabetic, PM; dietary needs, PM; dressing, PM; blood glucose monitor, 8:00 p.m.; medication administration, 8:00 p.m.; diabetic, overnight; and dietary needs (Mo, Th, Fr) overnight.</p> <p>-July 5, 2024: activities, 6:00 a.m.; diabetic, 6:00 a.m.; dietary needs, 6:00 a.m.; dressing, 6:00 a.m.; housekeeping (We, Fr, Su) 6:00 a.m.; blood glucose monitor, 7:30 a.m.; medication administration, 7:30 a.m.; medication administration, 8:00 a.m.; percentage of meal eaten, 8:00 a.m.; blood glucose monitor, 11:30 a.m.; medication administration, 11:30 a.m.; percentage of meal eaten, 12:00 p.m.; medication administration, 4:00 p.m.; blood glucose monitor,</p> | 0 730                                                                                  |                                                                                                                          |  |                                                        |



Minnesota Department of Health

|                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                 |                                                                                                                          |                          |                                              |
|---------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|----------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>34822 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |                          | (X3) DATE SURVEY COMPLETED<br><br>07/11/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>HARDING PLACE |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br>24448 296TH AVENUE<br>PIERZ, MN 56364                                           |                          |                                              |
| (X4) ID<br>PREFIX<br>TAG                          | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ID<br>PREFIX<br>TAG                                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                              |
| 0 730                                             | <p>Continued From page 27</p> <p>4:30 p.m.; medication administration, 4:30 p.m.; percentage of meal eaten, 5:00 p.m.; activities, PM; diabetic, PM; dietary needs, PM; dressing, PM; blood glucose monitor, 8:00 p.m.; medication administration, 8:00 p.m.; diabetic, overnight; and dietary needs (Mo, Th, Fr) overnight.</p> <p>-July 6, 2024: activities, 6:00 a.m.; bathing (Tu, Sa), 6:00 a.m.; diabetic, 6:00 a.m.; dietary needs, 6:00 a.m.; dressing, 6:00 a.m.; laundry package (Tu, Sa), 6:00 a.m.; blood glucose monitor, 7:30 a.m.; medication administration, 7:30 a.m.; medication administration, 8:00 a.m.; percentage of meal eaten, 8:00 a.m.; blood glucose monitor, 11:30 a.m.; medication administration, 11:30 a.m.; percentage of meal eaten, 12:00 p.m.; medication administration, 4:00 p.m.; blood glucose monitor, 4:30 p.m.; medication administration, 4:30 p.m.; percentage of meal eaten, 5:00 p.m.; activities, PM; diabetic, PM; dietary needs, PM; dressing, PM; blood glucose monitor, 8:00 p.m.; medication administration, 8:00 p.m.; and diabetic, overnight.</p> <p>-July 7, 2024: activities, 6:00 a.m.; diabetic, 6:00 a.m.; dietary needs, 6:00 a.m.; dressing, 6:00 a.m.; housekeeping (We, Fr, Su) 6:00 a.m.; blood glucose monitor, 7:30 a.m.; percentage of meal eaten, 5:00 p.m.; and dietary needs, PM.</p> <p>On July 10, 2024, at approximately 1:10 p.m., licensed assisted living director in residency (LALDIR)-B stated they are unaware if anybody audits the resident's service delivery records for documentation, and they take staff at their word the services are being completed.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days.</p> | 0 730                                                           |                                                                                                                          |                          |                                              |



Minnesota Department of Health

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                        |                                                                                                                          |  |                                                        |
|----------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34822</b>              | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>07/11/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HARDING PLACE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>24448 296TH AVENUE<br/>PIERZ, MN 56364</b> |                                                                                                                          |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ID<br>PREFIX<br>TAG                                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| 0 780<br>SS=F                                            | <p><b>144G.45 Subd. 2 (a) (1) Fire protection and physical environment</b></p> <p>(a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and:</p> <p>(1) for dwellings or sleeping units, as defined in the State Fire Code:</p> <p>(i) provide smoke alarms in each room used for sleeping purposes;</p> <p>(ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms;</p> <p>(iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics;</p> <p>(iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and</p> <p>(v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated;</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on observation and interview, the licensee failed to provide smoke alarms that complied with fire protection requirements. This had the potential to directly affect all residents, staff, and visitors.</p> <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</p> | 0 780                                                                                  |                                                                                                                          |  |                                                        |



Minnesota Department of Health

|                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                 |                                                                                                                          |  |                                              |
|---------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>34822 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br>07/11/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>HARDING PLACE |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br>24448 296TH AVENUE<br>PIERZ, MN 56364                                           |  |                                              |
| (X4) ID<br>PREFIX<br>TAG                          | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ID<br>PREFIX<br>TAG                                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                     |
| 0 780                                             | <p>Continued From page 29</p> <p>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).</p> <p>The findings include:</p> <p>On July 11, 2024, at 9:50 a.m., survey staff toured the facility with maintenance personnel (MP)-G. During the tour, survey staff observed the following:</p> <p>1. Smoke alarms were not installed in resident bedrooms 1, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 17, 18, 19, 20, 21, 22, and 23. During the facility tour interview, MP-G stated the licensee thought these resident bedrooms did not need smoke alarms since the bedroom walls did not enclose the rooms and there was open space between the top of the walls and the ceiling. The licensee failed to provide smoke alarms in each resident bedroom.</p> <p>2. When the smoke alarm in resident bedroom 2 was tested by MP-G, the smoke alarm installed outside this sleeping area was not actuated.</p> <p>3. When smoke alarms were tested by MP-G in apartment 24, none of the other smoke alarms in this 2 bedroom unit were actuated.</p> <p>The smoke alarms installed in the bedrooms and outside each sleeping area were not interconnected in these dwelling units. During the facility tour interview, MP-G verified these smoke alarms were not interconnected.</p> <p>4. A smoke alarm was not installed outside the sleeping area for resident bedrooms 16, 17, 18, and 19. The smoke alarm bracket on the ceiling was empty. During the facility tour interview, MP-G stated they did not know this smoke alarm was missing and the alarm would be reinstalled.</p> <p>5. The smoke alarms installed in resident rooms</p> | 0 780                                                           |                                                                                                                          |  |                                              |



Minnesota Department of Health

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                        |                                                                                                                          |  |                                                     |
|----------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>34822</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>07/11/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HARDING PLACE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>24448 296TH AVENUE<br/>PIERZ, MN 56364</b>                                   |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 780                                                    | Continued From page 30<br><br>16 and 28 did not work when tested by MP-G.<br>6. The smoke alarm installed in the living room<br>did not work when tested by MP-G.<br>These smoke alarms were not maintained in<br>proper operating condition. During the facility tour<br>interview, MP-G verified these smoke alarms<br>were not working.<br><br>TIME PERIOD FOR CORRECTION: Seven (7)<br>days                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 0 780                                                                  |                                                                                                                          |  |                                                     |
| 0 790<br>SS=F                                            | 144G.45 Subd. 2 (a) (2)-(3) Fire protection and<br>physical environment<br><br>(2) install and maintain portable fire<br>extinguishers in accordance with the State Fire<br>Code;<br><br>(3) install portable fire extinguishers having a<br>minimum 2-A:10-B:C rating within Group R-3<br>occupancies, as defined by the State Fire Code,<br>located so that the travel distance to the nearest<br>fire extinguisher does not exceed 75 feet, and<br>maintained in accordance with the State Fire<br>Code; and<br><br>This MN Requirement is not met as evidenced<br>by:<br>Based on observation and interview, the licensee<br>failed to install and maintain portable fire<br>extinguishers as required by statute. This<br>deficient condition had the potential to affect all<br>residents, staff, and visitors.<br><br>This practice resulted in a level two violation (a<br>violation that did not harm a resident's health or<br>safety but had the potential to have harmed a | 0 790                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                        |                                                                                                                          |  |                                                     |
|----------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>34822</b>                 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>07/11/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HARDING PLACE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>24448 296TH AVENUE<br/>PIERZ, MN 56364</b> |                                                                                                                          |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ID<br>PREFIX<br>TAG                                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 790                                                    | <p>Continued From page 31</p> <p>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).</p> <p>The findings include:</p> <p>On July 11, 2024, at 9:50 a.m., survey staff toured the facility with maintenance personnel (MP)-G. During the tour, survey staff observed the following:</p> <p>1. Monthly inspections were recorded for November, December, March, June and July on the back of the annual maintenance tags attached to the portable fire extinguishers. Fire extinguisher inspections must be conducted every month to ensure each extinguisher is in its designated place, it has not been tampered with, and there is no obvious physical damage or condition that would interfere with its use or operation.</p> <p>2. The fire extinguisher in the corridor near resident suite 4 was not mounted and stored on a wall shelf. Fire extinguishers must be available in an emergency and properly installed to prevent them from being moved or damaged. Fire extinguishers shall be mounted so the bottom is at least 4 inches off the ground and the top of the extinguisher no more than five feet from the floor.</p> <p>During the facility tour interview, MP-G verified fire extinguisher inspections had not been completed every month and one fire extinguisher was not properly installed.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days</p> | 0 790                                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                        |                                                                                                                          |  |                                                        |
|----------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34822</b>              | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>07/11/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HARDING PLACE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>24448 296TH AVENUE<br/>PIERZ, MN 56364</b> |                                                                                                                          |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ID<br>PREFIX<br>TAG                                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| 0 800                                                    | Continued From page 32                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 0 800                                                                                  |                                                                                                                          |  |                                                        |
| 0 800<br>SS=F                                            | <p><b>144G.45 Subd. 2 (a) (4) Fire protection and physical environment</b></p> <p>(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.</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on observation and interview, the licensee failed to provide the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors.</p> <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) 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).</p> <p>The findings include:</p> <p>On July 11, 2024, at 9:50 a.m., survey staff toured the facility with maintenance personnel (MP)-G. During the tour, survey staff observed the following:<br/>1. Double doors with an illuminated exit sign were installed at the front entrance to the facility. Survey staff and MP-G attempted to open the</p> | 0 800                                                                                  |                                                                                                                          |  |                                                        |



Minnesota Department of Health

|                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                 |                                                                                                                          |  |                                              |
|---------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>34822 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br>07/11/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>HARDING PLACE |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br>24448 296TH AVENUE<br>PIERZ, MN 56364                                           |  |                                              |
| (X4) ID<br>PREFIX<br>TAG                          | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ID<br>PREFIX<br>TAG                                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                     |
| 0 800                                             | Continued From page 33<br><br>right door using the panic bar to exit the building, and this door would not open.<br>2. Double doors with an illuminated exit sign were installed at the end of the corridor by resident suites 3 and 4. Survey staff and MP-G attempted to open the left door using the panic bar to exit the building, and this door would not open. The other exit door did not positively latch upon self-closing.<br>3. The exit door from the kitchen to the exterior of the building was difficult to open and close. Exit doors that do not operate properly could delay exiting in the event of an emergency. All paths of egress must provide unobstructed exiting.<br>During the facility tour interview, MP-G verified these exit doors were not working properly and stated the licensee was already aware of the problem and had received quotes for replacement doors.<br>4. Door closers were disconnected on both double doors for the exit from the smoke room to the exterior of the building.<br>5. The door closer for the mechanical room door had been disconnected.<br>Door closers must be maintained to protect the opening in which they were installed and to protect adjacent spaces. During the facility tour interview, MP-G verified these door closers were disconnected.<br>6. The floor seam was split in the common use resident toilet room.<br>7. The window blind was damaged in resident room 9.<br>8. There were brown stains on the ceiling tiles in resident bedroom 17 and outside this room in the hallway.<br>9. The window screen was torn in resident bedroom 22.<br>During the facility tour interview, MP-G verified | 0 800                                                           |                                                                                                                          |  |                                              |



Minnesota Department of Health

|                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                |                                                                                                                          |  |                                              |
|---------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>34822                | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br>07/11/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>HARDING PLACE |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | STREET ADDRESS, CITY, STATE, ZIP CODE<br>24448 296TH AVENUE<br>PIERZ, MN 56364 |                                                                                                                          |  |                                              |
| (X4) ID<br>PREFIX<br>TAG                          | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                     |
| 0 800                                             | Continued From page 34<br><br>the floor, ceiling, screen, and window blind required repair.<br>10. Extension cords were used in resident bedrooms 15 and 16. Improper use of extension cords creates a potential fire hazard. During the facility tour interview, MP-G stated extension cords should not be used and these cords would be removed.<br>11. Two electrical wall outlets were painted in the smoke room.<br>12. The covers were missing on two light fixtures in resident bedroom 25.<br>13. For apartment 24, the cover was missing for the exterior light fixture on the deck, and the trim was deteriorated on the exterior side of the door leading out to the deck.<br>14. Exterior trim was missing above the exit door for the living room. The exterior trim was deteriorated on the sides of this door.<br>15. The surface was rough and peeling on both exterior decks.<br>During the facility tour interview, MP-G verified the deck, door trim, light fixtures, and wall outlets required repair.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 0 800                                                                          |                                                                                                                          |  |                                              |
| 0 810<br>SS=F                                     | 144G.45 Subd. 2 (b)-(f) Fire protection and physical environment<br><br>(b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to:<br>(1) location and number of resident sleeping rooms;<br>(2) employee actions to be taken in the event of a fire or similar emergency;<br>(3) fire protection procedures necessary for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 0 810                                                                          |                                                                                                                          |  |                                              |



Minnesota Department of Health

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                        |                                                                                                                          |  |                                                     |
|----------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>34822</b>                 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>07/11/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HARDING PLACE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>24448 296TH AVENUE<br/>PIERZ, MN 56364</b> |                                                                                                                          |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ID<br>PREFIX<br>TAG                                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 810                                                    | <p>Continued From page 35</p> <p>residents; and</p> <p>(4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation.</p> <p>(c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter.</p> <p>(d) Fire safety and evacuation plans shall be readily available at all times within the facility.</p> <p>(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.</p> <p>(f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill.</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on record review and interview, the licensee failed to develop a fire safety and evacuation plan with the required content, make the plan readily available, and provide required training and drills. This had the potential to directly affect all residents, staff, and visitors.</p> <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) and was issued at a widespread scope (when problems are pervasive</p> | 0 810                                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                 |                                                                                                                          |  |                                              |
|---------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>34822 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br>07/11/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>HARDING PLACE |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br>24448 296TH AVENUE<br>PIERZ, MN 56364                                           |  |                                              |
| (X4) ID<br>PREFIX<br>TAG                          | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ID<br>PREFIX<br>TAG                                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                     |
| 0 810                                             | <p>Continued From page 36</p> <p>or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>On July 11, 2024, maintenance personnel (MP)-G provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and employee evacuation drills for the facility.</p> <p><b>FIRE SAFETY AND EVACUATION PLAN</b><br/>During an interview on July 11, 2024, at 12:15 p.m. licensed assisted living director (LALD)-A and licensed assisted living director in residency (LALDIR)-B explained the FSEP was stored in a cabinet in the office. It was further explained that the office door was sometimes kept locked and all staff had keys for the office door. The FSEP was not readily available at all times within the facility.</p> <p>Record review of the available documentation indicated the FSEP had not been developed relative to the facility's building layout and environmental risks. The plan referenced smoke compartments, smoke zones, fire doors, and hallway separation doors, but these areas were not identified in the plan. The 4.70 Fire Policy with a revision date of June 18, 2022, referenced smoke compartment doors, fire doors on magnetic holders, and fire doors, but these areas were not identified in the plan.</p> <p><b>TRAINING</b><br/>Record review indicated the licensee failed to provide training to employees on the FSEP upon hire and/or at least twice per year evident by the lack of training documentation. During an</p> | 0 810                                                           |                                                                                                                          |  |                                              |



Minnesota Department of Health

|                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                 |                                                                                                                          |  |                                              |
|---------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>34822 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br>07/11/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>HARDING PLACE |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br>24448 296TH AVENUE<br>PIERZ, MN 56364                                           |  |                                              |
| (X4) ID<br>PREFIX<br>TAG                          | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ID<br>PREFIX<br>TAG                                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                     |
| 0 810                                             | <p>Continued From page 37</p> <p>interview on July 11, 2024, at 12:15 p.m. licensed assisted living director (LALD)-A and licensed assisted living director in residency (LALDIR)-B explained new hire employees were trained on fire safety and evacuation as part of the emergency preparedness training from a third-party online training provider. New employees were not trained on the facility FSEP at the time of hire. LALD-A and LALDIR-B explained employees were trained on the facility FSEP annually and when the FSEP was updated. A FSEP training session for three employees was recorded on April 11, 2024. LALD-A and LALDIR-B verified training records were not available to support employee training on the FSEP had been completed at the frequency required by statute.</p> <p>Record review indicated the licensee failed to provide fire safety and evacuation training to residents at least once per year as evident by the lack of training documentation. No documentation for resident training completed in the last year was provided. During an interview on July 11, 2024, at 12:15 p.m. licensed assisted living director (LALD)-A and licensed assisted living director in residency (LALDIR)-B explained residents had been trained but records were not available to support this training had been completed.</p> <p>DRILLS</p> <p>Record review indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month as evident by fire drill reports lacking the required frequency. One employee fire drill was recorded in 2024, dated April 14, 2024. Nine employee fire drills were recorded in 2023. These drills were completed during</p> | 0 810                                                           |                                                                                                                          |  |                                              |



Minnesota Department of Health

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                        |                                                                                                                          |  |                                                     |
|----------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>34822</b>                 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>07/11/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HARDING PLACE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>24448 296TH AVENUE<br/>PIERZ, MN 56364</b> |                                                                                                                          |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ID<br>PREFIX<br>TAG                                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 810                                                    | Continued From page 38<br><br>February, May, June, August, September, and October. During an interview on July 11, 2024, at 12:15 p.m., LALD-A and LALDIR-B verified the employee evacuation drill frequency was not met.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 0 810                                                                                  |                                                                                                                          |  |                                                     |
| 0 910<br>SS=C                                            | 144G.50 Subd. 2 (a-b) Contract information<br><br>(a) The contract must include in a conspicuous place and manner on the contract the legal name and the health facility identification of the facility.<br>(b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of:<br>(1) the facility and contracted service provider when applicable;<br>(2) the licensee of the facility;<br>(3) the managing agent of the facility, if applicable; and<br>(4) the authorized agent for the facility.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to execute a written contract with the required content for two of two residents (R2, R3) with records reviewed.<br><br>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 | 0 910                                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                        |                                                                                                                          |  |                                                     |
|----------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>34822</b>                 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>07/11/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HARDING PLACE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>24448 296TH AVENUE<br/>PIERZ, MN 56364</b> |                                                                                                                          |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ID<br>PREFIX<br>TAG                                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 910                                                    | <p>Continued From page 39</p> <p>the residents).</p> <p>The findings include:</p> <p>R2's and R3's Assisted Living Contracts both dated, August 1, 2021, indicated the licensee held an Assisted Living license, however the contract lacked the following required information:</p> <ul style="list-style-type: none"><li>- The facility's health identification number (HFID); and</li><li>- The name, telephone number, and physical mailing address, which may not be a public or private post office box, of:<ul style="list-style-type: none"><li>(1) the facility and contracted service provider when applicable;</li><li>(2) the licensee of the facility;</li><li>(3) the managing agent of the facility, if applicable; and</li><li>(4) the authorized agent for the facility.</li></ul></li></ul> <p>On July 11, 2024, at 9:00 a.m., licensed assisted living director (LALD)-A stated they were unaware resident contracts were missing required information and stated when contract updates are made, that was typically handled by the licensee's management company who then informs the facilities when contracts need to be re-signed. LALD-A stated they did not recall a contract change during their employment with the licensee, but the director of the licensee was responsible for ensuring contracts were updated accordingly.</p> <p>Licensee policy titled 1.07 Assisted Living Contract Contents dated last revised August 1, 2021, did not address whether the facility's HFID number should be included. The policy did indicate the following information would be included:</p> <p>1. Name, telephone number and physical</p> | 0 910                                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                        |                                                                                                                          |  |                                                        |
|----------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34822</b>              | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>07/11/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HARDING PLACE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>24448 296TH AVENUE<br/>PIERZ, MN 56364</b> |                                                                                                                          |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | ID<br>PREFIX<br>TAG                                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| 0 910                                                    | Continued From page 40<br><br>mailing address of:<br>a. The facility and contracted service provider<br>when applicable;<br>b. The licensee of the facility;<br>c. The managing agent of the facility, if<br>applicable; and<br>d. The authorized agent for the facility.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one<br>(21) days.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 0 910                                                                                  |                                                                                                                          |  |                                                        |
| 0 920<br>SS=C                                            | 144G.50 Subd. 2 (c) Contract information<br><br>(c) The contract must include:<br>(1) a disclosure of the category of assisted living<br>facility license held by the facility and, if the facility<br>is not an assisted living facility with dementia<br>care, a disclosure that it does not hold an<br>assisted living facility with dementia care license;<br>(2) a description of all the terms and conditions of<br>the contract, including a description of and any<br>limitations to the housing or assisted living<br>services to be provided for the contracted<br>amount;<br>(3) a delineation of the cost and nature of any<br>other services to be provided for an additional<br>fee;<br>(4) a delineation and description of any additional<br>fees the resident may be required to pay if the<br>resident's condition changes during the term of<br>the contract;<br>(5) a delineation of the grounds under which the<br>resident may be transferred or have housing or<br>services terminated or be subject to an<br>emergency relocation;<br>(6) billing and payment procedures and<br>requirements; and | 0 920                                                                                  |                                                                                                                          |  |                                                        |



Minnesota Department of Health

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                        |                                                                                                                          |  |                                                     |
|----------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>34822</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>07/11/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HARDING PLACE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>24448 296TH AVENUE<br/>PIERZ, MN 56364</b>                                   |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 920                                                    | <p>Continued From page 41</p> <p>(7) disclosure of the facility's ability to provide specialized diets.</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on interview and record review, the licensee failed to execute a written contract with the required content for two of two residents (R2, R3) with records reviewed.</p> <p>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).</p> <p>The findings include:</p> <p>R2's and R3's Assisted Living Contracts both dated, August 1, 2021, indicated the licensee held an Assisted Living license, however the contract lacked the following required information:<br/>- A disclosure of the category of assisted living facility license held by the facility and, if the facility is not an assisted living facility with dementia care, a disclosure that it does not hold an assisted living facility with dementia care license.</p> <p>On July 11, 2024, at 9:00 a.m., licensed assisted living director (LALD)-A stated they were unaware resident contracts were missing required information and stated when contract updates are made, that was typically handled by the licensee's management company who then informs the facilities when contracts need to be re-signed. LALD-A stated they did not recall a contract change during their employment with the</p> | 0 920                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                        |                                                                                                                          |  |                                                     |
|----------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>34822</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>07/11/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HARDING PLACE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>24448 296TH AVENUE<br/>PIERZ, MN 56364</b>                                   |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 920                                                    | <p>Continued From page 42</p> <p>licensee, but the director of the licensee was responsible for ensuring contracts were updated accordingly.</p> <p>Licensee policy titled 1.07 Assisted Living Contract Contents dated last revised August 1, 2021, indicated the contract would include a disclosure of the category of assisted living facility licensed held by the facility and, if the facility is not an assisted living facility with dementia care, a disclosure that it does not hold an assisted living facility with dementia care license.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days.</p>                                                                                                                                                                                                                          | 0 920                                                                  |                                                                                                                          |  |                                                     |
| 0 930<br>SS=C                                            | <p>144G.50 Subd. 2 (d-e; 1-4) Contract information</p> <p>(d) The contract must include a description of the facility's complaint resolution process available to residents, including the name and contact information of the person representing the facility who is designated to handle and resolve complaints.</p> <p>(e) The contract must include a clear and conspicuous notice of:</p> <p>(1) the right under section 144G.54 to appeal the termination of an assisted living contract;</p> <p>(2) the facility's policy regarding transfer of residents within the facility, under what circumstances a transfer may occur, and the circumstances under which resident consent is required for a transfer;</p> <p>(3) contact information for the Office of Ombudsman for Long-Term Care, the Ombudsman for Mental Health and Developmental Disabilities, and the Office of</p> | 0 930                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                        |                                                                                                                          |  |                                                     |
|----------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>34822</b>                 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>07/11/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HARDING PLACE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>24448 296TH AVENUE<br/>PIERZ, MN 56364</b> |                                                                                                                          |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ID<br>PREFIX<br>TAG                                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 930                                                    | <p>Continued From page 43</p> <p>Health Facility Complaints;<br/>(4) the resident's right to obtain services from an unaffiliated service provider;</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on interview and record review, the licensee failed to execute a written contract with the required content for two of two residents (R2, R3) with records reviewed.</p> <p>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).</p> <p>The findings include:</p> <p>R2's and R3's Assisted Living Contracts both dated, August 1, 2021, indicated the licensee held an Assisted Living license, however the contract lacked the following required information:<br/>-A description of the facility's complaint resolution process available to residents, including the name and contact information of the person representing the facility who is designated to handle and resolve complaints;<br/>-Contact information for the Office of Ombudsman for Long-Term Care, the Ombudsman for Mental Health and Developmental Disabilities, and the Office of Health Facility Complaints.</p> <p>On July 11, 2024, at 9:00 a.m., licensed assisted living director (LALD)-A stated they were unaware resident contracts were missing required</p> | 0 930                                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                        |                                                                                                                          |  |                                                     |
|----------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>34822</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>07/11/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HARDING PLACE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>24448 296TH AVENUE<br/>PIERZ, MN 56364</b>                                   |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 930                                                    | <p>Continued From page 44</p> <p>information and stated when contract updates are made, that was typically handled by the licensee's management company who then informs the facilities when contracts need to be re-signed. LALD-A stated they did not recall a contract change during their employment with the licensee, but the director of the licensee was responsible for ensuring contracts were updated accordingly.</p> <p>Licensee policy titled 1.07 Assisted Living Contract Contents dated last revised August 1, 2021, indicated the contract would include a description of facility's complaint resolution process available to residents, including the name and contact information of the person representing the facility who is designated to handle and resolve complaints, contact information for the Office of Ombudsman for Long Term Care, the Ombudsman for Mental Health and Developmental Disabilities, and the Office of Health Facility Complaints.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days.</p> | 0 930                                                                  |                                                                                                                          |  |                                                     |
| 0 940<br>SS=C                                            | <p>144G.50 Subd. 2 (e; 5-7) Contract information</p> <p>(5) a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including:</p> <p>(i) whether the facility is enrolled with the commissioner of human services to provide customized living services under medical assistance waivers;</p> <p>(ii) whether the facility has an agreement to</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 0 940                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                        |                                                                                                                          |  |                                                     |
|----------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>34822</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>07/11/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HARDING PLACE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>24448 296TH AVENUE<br/>PIERZ, MN 56364</b>                                   |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 940                                                    | <p>Continued From page 45</p> <p>provide housing support under section 256I.04, subdivision 2, paragraph (b);</p> <p>(iii) whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided;</p> <p>(iv) whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required;</p> <p>(v) a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent;</p> <p>(vi) a statement that residents may be eligible for assistance with rent through the housing support program; and</p> <p>(vii) a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program;</p> <p>(6) the contact information to obtain long-term care consulting services under section 256B.0911; and</p> <p>(7) the toll-free phone number for the Minnesota Adult Abuse Reporting Center.</p> <p>This MN Requirement is not met as evidenced by:</p> <p>Based on interview and record review, the licensee failed to execute a written contract with the required content for two of two residents (R2, R3) with records reviewed.</p> <p>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</p> | 0 940                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                        |                                                                                                                          |  |                                                        |
|----------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34822</b>              | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>07/11/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HARDING PLACE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>24448 296TH AVENUE<br/>PIERZ, MN 56364</b> |                                                                                                                          |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ID<br>PREFIX<br>TAG                                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| 0 940                                                    | <p>Continued From page 46</p> <p>or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>R2's and R3's Assisted Living Contracts both dated, August 1, 2021, indicated the licensee held an Assisted Living license, however the contract lacked the following required information:<br/>-The toll-free phone number for the Minnesota Adult Abuse Reporting Center.</p> <p>On July 11, 2024, at 9:00 a.m., licensed assisted living director (LALD)-A stated they were unaware resident contracts were missing required information and stated when contract updates are made, that was typically handled by the licensee's management company who then informs the facilities when contracts need to be re-signed. LALD-A stated they did not recall a contract change during their employment with the licensee, but the director of the licensee was responsible for ensuring contracts were updated accordingly.</p> <p>Licensee policy titled 1.07 Assisted Living Contract Contents dated last revised August 1, 2021, indicated the contract would include the toll-free phone number for Minnesota Adult Abuse Reporting Center.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days.</p> | 0 940                                                                                  |                                                                                                                          |  |                                                        |
| 0 950<br>SS=C                                            | 144G.50 Subd. 3 Designation of representative                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 0 950                                                                                  |                                                                                                                          |  |                                                        |



Minnesota Department of Health

|                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                |                                                                                                                          |  |                                              |
|---------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>34822                | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br>07/11/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>HARDING PLACE |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br>24448 296TH AVENUE<br>PIERZ, MN 56364 |                                                                                                                          |  |                                              |
| (X4) ID<br>PREFIX<br>TAG                          | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                     |
| 0 950                                             | <p>Continued From page 47</p> <p>(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:</p> <p>"RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES.</p> <p>You have the right to name anyone as your "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."</p> <p>(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.</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on interview and record review, the licensee failed to offer the resident the opportunity to identify a designated representative in writing with the required statutory language for two of two residents (R2, R3) reviewed.</p> <p>This practice resulted in a level one violation (a</p> | 0 950                                                                          |                                                                                                                          |  |                                              |



Minnesota Department of Health

|                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                |                                                                                                                          |  |                                              |
|---------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>34822                | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br>07/11/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>HARDING PLACE |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br>24448 296TH AVENUE<br>PIERZ, MN 56364 |                                                                                                                          |  |                                              |
| (X4) ID<br>PREFIX<br>TAG                          | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                     |
| 0 950                                             | <p>Continued From page 48</p> <p>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).</p> <p>The findings include:</p> <p>R2<br/>R2's Assisted Living Contract signed August 1, 2021, did not include language to provide the resident an opportunity to identify a designated representative.</p> <p>R2's Service Plan (Private)- Addendum to Contract signed September 26, 2022, included an area for a resident to decline to name a designated representative, but did not include the verbatim language, and did not include an area for a designated representative's information should the resident choose to have one. R2's record did not include a verbatim notice separate from the contract.</p> <p>R3<br/>R3's Assisted Living Contract signed August 1, 2021, did not include language to provide the resident an opportunity to identify a designated representative.</p> <p>R3's Service Plan (Waiver)- Addendum to Contract signed September 30, 2021, included an area for a resident to decline to name a designated representative, but did not include the verbatim language, and did not include an area for a designated representative's information should the resident choose to have one. R3's record did not include a verbatim notice separate</p> | 0 950                                                                          |                                                                                                                          |  |                                              |



Minnesota Department of Health

|                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                |                                                                                                                          |  |                                              |
|---------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>34822                | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br>07/11/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>HARDING PLACE |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | STREET ADDRESS, CITY, STATE, ZIP CODE<br>24448 296TH AVENUE<br>PIERZ, MN 56364 |                                                                                                                          |  |                                              |
| (X4) ID<br>PREFIX<br>TAG                          | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                     |
| 0 950                                             | Continued From page 49<br><br>from the contract.<br><br>On July 11, 2024, at 9:00 a.m., licensed assisted living director (LALD)-A stated they were unaware resident contracts were missing required information and stated when contract updates are made, that was typically handled by the licensee's management company who then informs the facilities when contracts need to be re-signed. LALD-A stated they did not recall a contract change during their employment with the licensee, but the director of the licensee was responsible for ensuring contracts were updated accordingly.<br><br>Licensee policy titled 1.07 Assisted Living Contract Contents dated last revised August 1, 2021, did not address designative of a representative.<br><br>No further information provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 0 950                                                                          |                                                                                                                          |  |                                              |
| 0 970<br>SS=C                                     | 144G.50 Subd. 5 Waivers of liability prohibited<br><br>The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law.<br><br>This MN Requirement is not met as evidenced by:                                                                                                                                                                                                                                                                                                                                 | 0 970                                                                          |                                                                                                                          |  |                                              |



Minnesota Department of Health

|                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                |                                                                                                                          |  |                                              |
|---------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>34822                | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br>07/11/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>HARDING PLACE |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>24448 296TH AVENUE<br>PIERZ, MN 56364 |                                                                                                                          |  |                                              |
| (X4) ID<br>PREFIX<br>TAG                          | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                     |
| 0 970                                             | <p>Continued From page 50</p> <p>Based on interview and record review, the licensee failed to ensure the contract for assisted living did not include a waiver of the licensee's liability for two of two residents (R2, R3) reviewed.</p> <p>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).</p> <p>The findings include:</p> <p>R2<br/>R2's Assisted Living Contract signed August 1, 2021, included the following language: "Provider is not liable to Resident or Resident's guests for any injury, death or property damage occurring in the Apartment or on Provider's premises unless such injury, death or property damage occurs as the result of Provider's own negligent acts or omissions, or those of it's employees, officers, managers, owners or agents. Provider is also not liable for any injury, death or damage occurring as the result of Resident's receipt of health-related, supportive or other services from third party providers. Unless caused by one of the aforementioned excepted reasons, Resident agrees to hold Provider harmless from any and all claims for injuries, property damage or any other loss resulting from an accident or other occurrence in the Apartment or on Provider's premises."</p> <p>R3<br/>R3's Assisted Living Contract signed August 1,</p> | 0 970                                                                          |                                                                                                                          |  |                                              |



Minnesota Department of Health

|                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                |                                                                                                                          |  |                                              |
|---------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>34822                | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br>07/11/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>HARDING PLACE |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br>24448 296TH AVENUE<br>PIERZ, MN 56364 |                                                                                                                          |  |                                              |
| (X4) ID<br>PREFIX<br>TAG                          | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                     |
| 0 970                                             | Continued From page 51<br><br>2021, included the following language: "Provider is not liable to Resident or Resident's guests for any injury, death or property damage occurring in the Apartment or on Provider's premises unless such injury, death or property damage occurs as the result of Provider's own negligent acts or omissions, or those of it's employees, officers, managers, owners or agents. Provider is also not liable for any injury, death or damage occurring as the result of Resident's receipt of health-related, supportive or other services from third party providers. Unless caused by one of the aforementioned excepted reasons, Resident agrees to hold Provider harmless from any and all claims for injuries, property damage or any other loss resulting from an accident or other occurrence in the Apartment or on Provider's premises."<br><br>On July 10, 2024, at approximately 1:10 p.m., licensed assisted living director in residency (LALDIR)-B stated they were unaware waivers of liability were prohibited in assisted living contracts.<br><br>Licensee policy titled 1.07 Assisted Living Contract Contents dated last revised August 1, 2021, did not address waivers of liability or whether a waiver was permitted.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 0 970                                                                          |                                                                                                                          |  |                                              |
| 01500<br>SS=F                                     | 144G.63 Subd. 5 Required annual training<br><br>(a) All staff that perform direct services must complete at least eight hours of annual training                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 01500                                                                          |                                                                                                                          |  |                                              |



Minnesota Department of Health

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                        |                                                                                                                          |  |                                                        |
|----------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34822</b>              | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>07/11/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HARDING PLACE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>24448 296TH AVENUE<br/>PIERZ, MN 56364</b> |                                                                                                                          |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ID<br>PREFIX<br>TAG                                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| 01500                                                    | <p>Continued From page 52</p> <p>for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include:</p> <p>(1) training on reporting of maltreatment of vulnerable adults under section 626.557;</p> <p>(2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights;</p> <p>(3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases;</p> <p>(4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders;</p> <p>(5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and</p> <p>(6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person.</p> <p>(b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following</p> | 01500                                                                                  |                                                                                                                          |  |                                                        |



Minnesota Department of Health

|                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                |                                                                                                                          |  |                                              |
|---------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>34822                | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br>07/11/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>HARDING PLACE |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | STREET ADDRESS, CITY, STATE, ZIP CODE<br>24448 296TH AVENUE<br>PIERZ, MN 56364 |                                                                                                                          |  |                                              |
| (X4) ID<br>PREFIX<br>TAG                          | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                     |
| 01500                                             | <p>Continued From page 53</p> <p>topics:</p> <p>(1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication;</p> <p>(2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or</p> <p>(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.</p> <p>This MN Requirement is not met as evidenced by:</p> <p>Based on observation, interview, and record review, the licensee failed to ensure their staff received at least eight hours of annual training including all required topics for each twelve months of employment for two of two employees (unlicensed personnel (ULP)-E, ULP-F).</p> <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 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).</p> <p>The findings include:</p> <p>ULP-F</p> <p>ULP-F was hired June 19, 2017, to perform direct care services for residents of the licensee.</p> | 01500                                                                          |                                                                                                                          |  |                                              |



Minnesota Department of Health

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                        |                                                                                                                          |  |                                                     |
|----------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>34822</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>07/11/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HARDING PLACE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>24448 296TH AVENUE<br/>PIERZ, MN 56364</b>                                   |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01500                                                    | <p>Continued From page 54</p> <p>On July 9, 2024, at approximately 2:00 p.m., the surveyor observed ULP-F arrive to the facility, count the controlled medications with ULP-E, and begin working with residents of the facility.</p> <p>ULP-F's employee record contained an Educare (on-line training course) transcript printed July 9, 2024, a Narcan skills competency dated June 25, 2024, a skills review documentation form dated March 11, 2021, a staff training and test out form related to fall prevention and management dated March 11, 2021, and an acknowledgement of awareness of the provider's comprehensive home care resource manual and housing with services policy and procedure manual dated December 4, 2020.</p> <p>ULP-F's record lacked evidence of any trainings from the anniversary of their date of hire on June 19, 2023, to June 19, 2024. ULP-F's most recent trainings were as follows:</p> <ul style="list-style-type: none"><li>-assisted living bill of rights, MN, .75 hours completed March 17, 2023;</li><li>-dementia, a refresher ND BON 2137, 1.0 hours completed March 19, 2023;</li><li>-dementia, activities, a balanced approach, .75 hours completed March 29, 2023;</li><li>-dementia, communication, overview, 1.0 hours completed March 29, 2023;</li><li>-dementia, problem solving, overview, .75 hours completed March 30, 2023;</li><li>-dementia, the face of dementia, the journey, 1.0 hours completed March 30, 2023;</li><li>-emergency preparedness, human hazards, MN AL, .75 hours completed April 4, 2023;</li><li>-emergency preparedness, overview, MN AL, .75 hours completed April 4, 2023;</li><li>-emergency preparedness, site and natural hazards, MN AL, 1.0 hours completed April 4, 2023;</li></ul> | 01500                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                 |                                                                                                                          |  |                                              |
|---------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>34822 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br>07/11/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>HARDING PLACE |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br>24448 296TH AVENUE<br>PIERZ, MN 56364                                           |  |                                              |
| (X4) ID<br>PREFIX<br>TAG                          | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ID<br>PREFIX<br>TAG                                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                     |
| 01500                                             | <p>Continued From page 55</p> <p>-infection control techniques NDBON 2233, 1.0 hours completed April 8, 2023;<br/>-person-centered care principles, .5 hours completed April 5, 2023;<br/>-vulnerable adult refresher, MN, .75 hours completed April 5, 2023; and<br/>-test only, client mobility, exercise and ambulation, .25 hours completed April 5, 2023.</p> <p>ULP-F's record contained none of the required trainings for the preceding 12 months from the anniversary of their hire date. In addition, ULP-F's training records noted above from March and April 2023 totaled 10.25 hours, however lacked inclusion of the following required topics:<br/>-review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures.</p> <p>ULP-E<br/>ULP-E was hired December 10, 2008, to perform direct care services for residents of the licensee.</p> <p>On July 9, 2024, at approximately 7:30 a.m., the surveyor observed ULP-E assist multiple residents with treatment and medication administration services.</p> <p>ULP-E's employee record contained an Educare transcript printed July 8, 2024, and a skills review documentation form dated March 11, 2021.</p> <p>ULP-E's trainings from the anniversary of their date of hire on December 10, 2022, to December 10, 2023, were noted as follows:<br/>-assisted living bill of rights, MN, .75 hours completed January 13, 2023;<br/>-assisted living bill of rights, MN.75 hours completed December 3, 2023;</p> | 01500                                                           |                                                                                                                          |  |                                              |



Minnesota Department of Health

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                        |                                                                                                                          |  |                                                     |
|----------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>34822</b>                 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>07/11/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HARDING PLACE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>24448 296TH AVENUE<br/>PIERZ, MN 56364</b> |                                                                                                                          |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ID<br>PREFIX<br>TAG                                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01500                                                    | <p>Continued From page 56</p> <p>-bed rails, .5 hours completed August 27, 2023;<br/>-bed rails, .5 hours completed December 3, 2023;<br/>-dementia, a refresher, 1.0 hours completed January 13, 2023;<br/>-dementia, a refresher NDBON 2230, 1.0 hours completed December 3, 2023;<br/>-dementia, activities, a balanced approach, .75 hours completed January 13, 2023;<br/>-dementia, communication, overview, 1.0 hours completed January 15, 2023;<br/>-dementia, problem solving, overview, .75 hours completed January 15, 2023;<br/>-dementia, the face of dementia, the journey, 1.0 hours completed January 15, 2023;<br/>-emergency preparedness, human hazards, MN AL, .75 hours completed January 15, 2023,<br/>-emergency preparedness, overview, MN AL, .75 hours completed January 18, 2023;<br/>-emergency preparedness, site and natural hazards, MN AL, 1.0 hours completed January 22, 2023;<br/>-infection control techniques NDBON 2233, 1.0 hours completed January 22, 2023;<br/>-person-centered care principles, .5 hours completed January 22, 2023; and<br/>-vulnerable adult refresher, MN, .75 hours completed January 22, 2023.</p> <p>ULP-E's trainings during the above-mentioned timeframe totaled 12.5 hours, however lacked inclusion of the following required topics:<br/>-review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures.</p> <p>On July 9, 2024, at approximately 12:45 p.m., licensed assisted living director (LALD)-A stated the licensee held a company-wide annual in-service, usually in November and they also</p> | 01500                                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                        |                                                                                                                          |  |                                                        |
|----------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34822</b>              | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>07/11/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HARDING PLACE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>24448 296TH AVENUE<br/>PIERZ, MN 56364</b> |                                                                                                                          |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ID<br>PREFIX<br>TAG                                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| 01500                                                    | <p>Continued From page 57</p> <p>utilized Educare to meet annual training requirements. LALD-A was unable to articulate how the licensee tracked due dates of annual training and stated the licensed assisted living director in residency ((LALDIR)-B) had been with the facility since January and, "she inherited some messes."</p> <p>On July 10, 2024, at approximately 1:10 p.m., LALDIR-B stated they were not aware of the annual training requirements for unlicensed personnel. LALDIR-B stated, "I am sure there is some continuing ed [education] they have to do, outside of that, I don't know how many hours of continuing ed are required for them." LALDIR-B stated they were not familiar with how to locate Minnesota Assisted Living Statutes or Rules.</p> <p>Licensee's Required Annual Training policy dated August 1, 2021, indicated all personnel that perform direct care services will complete at least eight hours of annual training for each 12 months of employment in the required topics.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days.</p> | 01500                                                                                  |                                                                                                                          |  |                                                        |
| 01530<br>SS=D                                            | <p><b>144G.64 TRAINING IN DEMENTIA CARE<br/>REQUIRED</b></p> <p>(a) All assisted living facilities must meet the following training requirements:<br/>(1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 01530                                                                                  |                                                                                                                          |  |                                                        |



Minnesota Department of Health

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                        |                                                                                                                          |  |                                                     |
|----------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>34822</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>07/11/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HARDING PLACE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>24448 296TH AVENUE<br/>PIERZ, MN 56364</b>                                   |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01530                                                    | <p>Continued From page 58</p> <p>related to dementia care for each 12 months of employment thereafter;<br/>(2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter;</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on observation, interview, and record review, the licensee failed to provide an employee with the required two hours of annual dementia care training for one of two unlicensed personnel (ULP)-F.</p> <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) 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).</p> <p>The findings include:</p> <p>ULP-F was hired June 19, 2017, to perform direct</p> | 01530                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                        |                                                                                                                          |  |                                                     |
|----------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>34822</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>07/11/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HARDING PLACE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>24448 296TH AVENUE<br/>PIERZ, MN 56364</b>                                   |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01530                                                    | <p>Continued From page 59</p> <p>care services for residents of the licensee.</p> <p>On July 9, 2024, at approximately 2:00 p.m., the surveyor observed ULP-F arrive to the facility, count the controlled medications with ULP-E, and begin working with residents of the facility.</p> <p>ULP-F's employee record contained an Educare (on-line training course) transcript printed July 9, 2024, a Narcan skills competency dated June 25, 2024, a skills review documentation form dated March 11, 2021, a staff training and test out form related to fall prevention and management dated March 11, 2021, and an acknowledgement of awareness of the provider's comprehensive home care resource manual and housing with services policy and procedure manual dated December 4, 2020.</p> <p>ULP-F's record lacked evidence of any trainings from the anniversary of their date of hire on June 19, 2023, to June 19, 2024. ULP-F's most recent dementia care trainings were as follows:<br/>-dementia, a refresher ND BON 2137, 1.0 hours completed March 19, 2023;<br/>-dementia, activities, a balanced approach, .75 hours completed March 29, 2023;<br/>-dementia, communication, overview, 1.0 hours completed March 29, 2023;<br/>-dementia, problem solving, overview, .75 hours completed March 30, 2023; and<br/>-dementia, the face of dementia, the journey, 1.0 hours completed March 30, 2023.</p> <p>ULP-F's record lacked evidence of at least two hours of annual dementia training in areas of required training to include: (1) an explanation of Alzheimer's disease and other dementias; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; (4)</p> | 01530                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                 |                                                                                                                          |  |                                              |
|---------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>34822 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br>07/11/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>HARDING PLACE |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br>24448 296TH AVENUE<br>PIERZ, MN 56364                                           |  |                                              |
| (X4) ID<br>PREFIX<br>TAG                          | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ID<br>PREFIX<br>TAG                                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                     |
| 01530                                             | <p>Continued From page 60</p> <p>communication skills; and (5) person-centered planning and service delivery.</p> <p>On July 9, 2024, at approximately 12:45 p.m., licensed assisted living director (LALD)-A stated the licensee held a company-wide annual in-service, usually in November and they also utilized Educare to meet annual training requirements. LALD-A was unable to articulate how the licensee tracked due dates of annual training and stated the licensed assisted living director in residency ((LALDIR)-B) had been with the facility since January and, "she inherited some messes."</p> <p>On July 10, 2024, at approximately 1:10 p.m., LALDIR-B stated they were not aware of the annual training requirements for unlicensed personnel. LALDIR-B stated, "I am sure there is some continuing ed [education] they have to do, outside of that, I don't know how many hours of continuing ed are required for them." LALDIR-B stated they were not familiar with how to locate Minnesota Assisted Living Statutes or Rules.</p> <p>Licensee's Required Annual Training policy dated August 1, 2021, indicated all personnel that perform direct care services will complete at least eight hours of annual training for each 12 months of employment in the required topics.</p> <p>Licensee's Dementia Training Notice policy dated August 1, 2021, indicated the licensee would provide two hours of additional dementia training to staff annually.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days.</p> | 01530                                                           |                                                                                                                          |  |                                              |



Minnesota Department of Health

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                        |                                                                                                                          |  |                                                     |
|----------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>34822</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>07/11/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HARDING PLACE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>24448 296TH AVENUE<br/>PIERZ, MN 56364</b>                                   |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01910<br>SS=D                                            | <p><b>144G.71 Subd. 22 Disposition of medications</b></p> <p>(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.</p> <p>(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 medications and controlled substances.</p> <p>(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.</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on interview and record review, the licensee failed to complete documentation in the resident's record regarding the disposition of medication to include the medication strength, prescription number, quantity, to whom the medications were given, date of disposition, and names of staff involved in the disposition for one of one discharged resident (R1).</p> <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) and was issued at an isolated scope (when one or a limited number of</p> | 01910                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                        |                                                                                                                          |  |                                                     |
|----------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>34822</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>07/11/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HARDING PLACE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>24448 296TH AVENUE<br/>PIERZ, MN 56364</b>                                   |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01910                                                    | <p>Continued From page 62</p> <p>residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally).</p> <p>The findings include:</p> <p>R1's start of care with the licensee was March 26, 2020.</p> <p>R1's Resident Note dated March 17, 2024, indicated R1 was hospitalized following a fall on March 17, 2024.</p> <p>R1's Resident Note dated April 9, 2024, indicated R1 was at a care center following a hip fracture and an assessment would be completed upon R1's return.</p> <p>R1's Resident Note dated June 13, 2024, indicated the writer of the note was discharging R1 from the licensee. The note read, "Writer never met resident and he is residing at [name of care center]. County will eventually gather all of resident's belongings but has not done so yet."</p> <p>R1's Discharge Care Plan completed by clinical nurse supervisor (CNS)-D on June 13, 2024, indicated the licensee managed and administered R1's medications.</p> <p>R1's March 2024 Med Admin Summary (medication administration record (MAR)) indicated the licensee was managing the following of R1's scheduled medications: duloxetine 60 milligram (mg) capsules, levetiracetam 100mg tablets, levothyroxine 88 microgram (mcg) tablets, losartan 50mg tablets, Miralax 17 gram (gm), Tylenol 500mg tablets, vitamin D3 2000 international unit (IU) tablets, gabapentin 300mg capsules, aspirin 81mg</p> | 01910                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                        |                                                                                                                          |  |                                                     |
|----------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>34822</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>07/11/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HARDING PLACE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>24448 296TH AVENUE<br/>PIERZ, MN 56364</b>                                   |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01910                                                    | <p>Continued From page 63</p> <p>tablets, Certa-Vite tablets, famotidine 40mg tablets, and folic acid 1mg tablets. In addition, the MAR listed a topical medication, triamcinolone 0.1%, R1 was able to self-administer, and the following as needed (PRN) medications: Artificial Tears eye drops, diclofenac sodium (self-administer topically), Epi-Pen (ok to carry on person for self-administration), fluticasone nasal spray, Maalox, milk of magnesia, Robitussin DM, Aspercreme 4%/Lidocaine (self-administer topically), cough drops, HC cream (hydrocortisone cream), ibuprofen, triple antibiotic, and zinc oxide.</p> <p>R1's Medication Disposition record completed July 8, 2024, (during the survey) listed the following medications: Artificial Tears, Aspercreme, aspirin 81mg, Certa-Vite multivitamin, diclofenac sodium, famotidine, folic acid, HC cream, evothyroxine, losartan, and vitamin D3.</p> <p>R1's Medication Disposition record completed July 8, 2024, failed to address the following medications: duloxetine 60 mg capsules, levetiracetam 100mg tablets, Miralax 17gm, Tylenol 500mg tablets, gabapentin 300mg capsules, triamcinolone 0.1%, Epi-Pen, fluticasone nasal spray, Maalox, milk of magnesia, Robitussin DM, Aspercreme 4%/Lidocaine, cough drops, ibuprofen, triple antibiotic, and zinc oxide. In addition, the medication disposition record indicated the quantity of each medication disposed of was "1".</p> <p>On July 8, 2024, at 2:40 p.m., licensed assisted living director in residency (LALDIR)-B stated R1 left the licensee after a serious injury in March 2024, and stated the licensee did not learn R1</p> | 01910                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                        |                                                                                                                          |  |                                                        |
|----------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34822</b>              | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>07/11/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HARDING PLACE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>24448 296TH AVENUE<br/>PIERZ, MN 56364</b> |                                                                                                                          |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ID<br>PREFIX<br>TAG                                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| 01910                                                    | <p>Continued From page 64</p> <p>was not returning until June 2024.</p> <p>On July 9, 2024, at approximately 9:40 a.m., clinical nurse supervisor (CNS)-D stated she had never met R1, but when the licensee learned in June R1 was not returning, they reached out to the licensee's management company to find out how to discharge a resident they had never met. CNS-D stated sometime later, "a bunch of meds showed up in my office, I don't know where they came from", and "I don't know if [LALDIR-B] or a case manager put them in there. I got rid of them, that was last week." When the surveyor inquired why the quantity for each medication indicated only one, CNC-D stated they did not count any tablets but instead indicated it was one bottle, or one container of medication. CNS-D stated they did not know it was requirement to count out the tablets or quantity disposed of. When the surveyor questioned CNS-D about the medications prescribed to R1 but not listed on the medication disposition record, CNS-D stated they only addressed the medications that were dropped on their desk. In addition, CNS-D stated some of the PRN medications were "stock" medications provided by the licensee.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days.</p> | 01910                                                                                  |                                                                                                                          |  |                                                        |
| 02320<br>SS=D                                            | <p>144G.91 Subd. 4 (b) Appropriate care and services</p> <p>(b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 02320                                                                                  |                                                                                                                          |  |                                                        |



Minnesota Department of Health

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                        |                                                                                                                          |  |                                                        |
|----------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34822</b>              | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>07/11/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HARDING PLACE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>24448 296TH AVENUE<br/>PIERZ, MN 56364</b> |                                                                                                                          |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ID<br>PREFIX<br>TAG                                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| 02320                                                    | <p>Continued From page 65</p> <p>sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan.</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on observation, interview, and record review the licensee failed to ensure unlicensed personnel (ULP) followed appropriate medication administration procedures for one of two unlicensed personnel (ULP)-E observed during medication administration.</p> <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 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).</p> <p>The findings include:</p> <p>R3<br/>On July 9, 2024, at 7:26 a.m., the surveyor observed ULP-E administer R3's morning medications which included aspirin 81 milligram (mg) tablet. The surveyor observed the licensee utilized an electronic records system, Rtasks, which included specific instructions for medication administration. R3's 81mg tablet included instructions to chew the tablet before swallowing. ULP-E did not instruct R3 to chew the tablet before swallowing.</p> <p>R4<br/>On July 9, 2024, at 7:51 a.m., the surveyor observed ULP-E administer R4's morning</p> | 02320                                                                                  |                                                                                                                          |  |                                                        |



Minnesota Department of Health

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                        |                                                                                                                          |  |                                                        |
|----------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34822</b>              | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>07/11/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HARDING PLACE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>24448 296TH AVENUE<br/>PIERZ, MN 56364</b> |                                                                                                                          |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ID<br>PREFIX<br>TAG                                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| 02320                                                    | <p>Continued From page 66</p> <p>medications which included an albuterol 90 microgram (mcg) inhaler, two puffs. The Rtasks system indicated instructions to wait one to five minutes in between puffs. ULP-E did not instruct R4 to wait one to five minutes in between puffs.</p> <p>R5<br/>On July 9, 2024, at 8:11 a.m., the surveyor observed ULP-E administer R5's morning medications which included a Wixela Fluticasone Propionate 250/50 inhaler. The inhaler was kept in the box with the pharmacy label which instructed to inhale by mouth twice daily and to rinse mouth after use. ULP-E did not instruct R5 to rinse mouth after use.</p> <p>On July 9, 2024, at 8:32 a.m., the surveyor questioned ULP-E regarding the lack of instruction to R3 about chewing the aspirin. ULP-E declined to answer. The surveyor then questioned ULP-E about their training related to inhalers. ULP-E stated she recalled being trained to shake the inhaler, instruct residents to take a puff, to hold the puff, wait a minute or so, then to take the next puff. ULP-E stated they did not follow the instructions for R4 and R5's inhalers because she was used to the routine of residents doing what they wanted and previously disregarding instructions. The surveyor asked ULP-E if they were trained to have residents rinse their mouth following the use of inhalers. ULP-E stated yes.</p> <p>On July 10, 2024, at 9:38 a.m., clinical nurse supervisor (CNS)-D stated her expectation was staff follow the instructions as they are ordered to a "T". CNS-D stated they would need to conduct re-training with ULP-E.</p> <p>Licensee's policy titled 12.59 Inhaler dated August</p> | 02320                                                                                  |                                                                                                                          |  |                                                        |



Minnesota Department of Health

|                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                |                                                                                                                          |  |                                              |
|---------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>34822                | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br>07/11/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>HARDING PLACE |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br>24448 296TH AVENUE<br>PIERZ, MN 56364 |                                                                                                                          |  |                                              |
| (X4) ID<br>PREFIX<br>TAG                          | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                     |
| 02320                                             | Continued From page 67<br><br>1, 2021, indicated staff should wait at least one minute in between administering puffs of the same medication or wait at least five minutes before administering a different inhaled medication. Additionally, the policy indicated to provide the resident an opportunity to rinse their mouth following inhaler usage.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 02320                                                                          |                                                                                                                          |  |                                              |
| 02420<br>SS=F                                     | 144G.91 Subd. 14 Communication privacy<br><br>(a) Residents have the right to communicate privately with persons of their choice.<br>(b) If an assisted living facility is sending or receiving mail on behalf of residents, the assisted living facility must do so without interference.<br>(c) Residents must be provided access to a telephone to make and receive calls.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to protect resident's rights to communication privacy when the licensee required residents to track outgoing phone calls made by residents from a common area telephone.<br><br>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 | 02420                                                                          |                                                                                                                          |  |                                              |



Minnesota Department of Health

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                        |                                                                                                                          |  |                                                        |
|----------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34822</b>              | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>07/11/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HARDING PLACE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>24448 296TH AVENUE<br/>PIERZ, MN 56364</b> |                                                                                                                          |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ID<br>PREFIX<br>TAG                                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| 02420                                                    | <p>Continued From page 68</p> <p>of the residents).</p> <p>The findings include:</p> <p>On July 9, 2024, at approximately 12:20 p.m., the surveyor observed a landline telephone phone on the kitchen countertop near a resident common area. On the counter next to the telephone was a clipboard with a phone call log attached. Unlicensed personnel (ULP)-E stated it was a shared telephone utilized by the residents. The phone call log contained columns with the following headings: resident, date, time, who you are calling, and phone number. The call log was in use and had been utilized by four residents on the following dates: June 30, July 2, July 3, July 5, July 7, and July 9.</p> <p>On July 9, 2024, at 12:15 p.m., licensed assisted living director (LALD)-A stated they had not questioned the use of the phone call log as it had been in place "forever". Unlicensed personnel (ULP)-E stated they believed the phone call log was in use to track long-distance calls made by the residents so the licensee could bill the residents accordingly.</p> <p>On July 10, 2024, at approximately 9:40 a.m., clinical nurse supervisor (CNS)-D stated they were unaware the phone call log existed and stated they would feel violated if they had to log all of their outgoing calls. CNS-D stated even if residents are disoriented, they still have the right to privacy when making calls and should still be able to call 911 if needed.</p> <p>On July 10, 2024, at approximately 1:10 p.m., licensed assisted living director in residency (LALDIR)-B stated they noted the phone call log was present upon their hire and had inquired to</p> | 02420                                                                                  |                                                                                                                          |  |                                                        |



Minnesota Department of Health

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                        |                                                                                                                          |  |                                                        |
|----------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34822</b>              | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>07/11/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HARDING PLACE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>24448 296TH AVENUE<br/>PIERZ, MN 56364</b> |                                                                                                                          |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | ID<br>PREFIX<br>TAG                                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| 02420                                                    | <p>Continued From page 69</p> <p>the previous director about it. LALDIR-B stated they were told it was implemented due to one resident who had a tendency to call people constantly. LALDIR-B stated each month the staff bring them the phone call log from the previous month, and they shred it. LALDIR-B stated the licensee does not get charged for long-distance calls made from the common area phone, so they did not believe that was a valid reason to track outgoing calls. LALDIR-B stated tracking resident calls was a violation of their privacy.</p> <p>The licensee's undated blank admission packet provided a place to document resident's receipt of the "Bill of Rights" and included within was the Minnesota Bill of Rights for Assisted Living Residents. The Bill of Rights indicated residents have the right to communicate privately with persons of their choice.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days.</p> | 02420                                                                                  |                                                                                                                          |  |                                                        |





Minnesota Department of Health  
Food, Pools & Lodging Services  
P.O. BOX 64975  
ST. PAUL, MN 55164-0975  
651-201-4500

Type: Full  
Date: 07/08/24  
Time: 11:30:00  
Report: 1017241107

## Food and Beverage Establishment Inspection Report

Page 1

### Location:

Harding Place  
24448 296th Avenue  
Pierz, MN56364  
Morrison County, 49

### Establishment Info:

ID #: 0037890  
Risk:  
Announced Inspection: No

### License Categories:

Expires on: / /

### Operator:

Phone #: 3202773424  
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.

### 4-200 Equipment Design and Construction

#### 4-201.11BMN

MN Rule 4626.0506B Provide an exhaust ventilation hood that meets the requirements in the Minnesota Mechanical Code, Minnesota Rules, chapter 1346.

FIRE SUPPRESSION SYSTEM WAS LAST SERVICED AND INSPECTED IN 2020. CONTRACT WITH FIRE SUPPRESSION COMPANY ANNUALLY FOR SERVICE.

*Comply By: 07/08/24*

### 4-600 Cleaning Equipment and Utensils

#### 4-601.11C

MN Rule 4626.0840C Clean non-food contact surfaces of equipment and maintain free of accumulations of dust, dirt, food residue, and other debris.

OBSERVED FOOD DEBRIS ON CAN OPENER. CLEAN AND SANITIZE CAN OPENER AFTER EACH USE.

*Comply By: 07/08/24*

### Surface and Equipment Sanitizers

Hot Water: = at 167 F Degrees Fahrenheit  
Location: DISH MACHINE  
Violation Issued: No

Quaternary Ammonia: = 200 PPM at Degrees Fahrenheit  
Location: QUAT LOCATED IN SPRAY BOTTLE  
Violation Issued: No

### Food and Equipment Temperatures



Type: Full  
Date: 07/08/24  
Time: 11:30:00  
Report: 1017241107  
Harding Place

# Food and Beverage Establishment Inspection Report

Page 2

---

Process/Item: Cold Holding  
Temperature: 42 Degrees Fahrenheit - Location: PARMESAN CHEESE LOCATED IN UPRIGHT COOLER  
Violation Issued: No

---

Process/Item: Cold Holding  
Temperature: 42 Degrees Fahrenheit - Location: CHICKEN LOCATED IN UPRIGHT COOLER  
Violation Issued: No

---

---

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

---

## DISCUSSION:

AVOID BARE HAND CONTACT WITH READY TO EAT FOOD, HAND WASHING, EMPLOYEE ILLNESS LOG.

**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 1017241107 of 07/08/24.

Certified Food Protection Manager KATHERINE M. DEROSIER

Certification Number: FM 95936 Expires: 10/13/24

**Inspection report reviewed with person in charge and emailed.**

Signed: \_\_\_\_\_

Establishment Representative

Signed:  \_\_\_\_\_

NATE TOPP  
PUBLIC HEALTH SANITARIAN  
ST. CLOUD  
320.223.7333  
NATE.TOPP@STATE.MN.US



|                                                                                                                                                                                                                            |    |                                                                         |                                                                                            |                               |  |                   |  |                         |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----|-------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|-------------------------------|--|-------------------|--|-------------------------|--|
| Report #: 1017241107                                                                                                                                                                                                       |    | Food Establishment Inspection Report                                    |                                                                                            |                               |  |                   |  |                         |  |
| <div><div>Minnesota Department of Health<br/>Food, Pools &amp; Lodging Services<br/>P.O. BOX 64975<br/>ST. PAUL, MN 55164-0975</div></div> |    | No. of RF/PHI Categories Out                                            |                                                                                            | 0                             |  | Date 07/08/24     |  |                         |  |
|                                                                                                                                                                                                                            |    | No. of Repeat RF/PHI Categories Out                                     |                                                                                            | 0                             |  | Time In 11:30:00  |  |                         |  |
|                                                                                                                                                                                                                            |    | Legal Authority MN Rules Chapter 4626                                   |                                                                                            |                               |  | Time Out          |  |                         |  |
| Harding Place                                                                                                                                                                                                              |    | Address<br>24448 296th Avenue                                           |                                                                                            | City/State<br>Pierz, MN       |  | Zip Code<br>56364 |  | Telephone<br>3202773424 |  |
| License/Permit #<br>0037890                                                                                                                                                                                                |    | Permit Holder                                                           |                                                                                            | Purpose of Inspection<br>Full |  | Est Type          |  | Risk Category           |  |
| FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS                                                                                                                                                             |    |                                                                         |                                                                                            |                               |  |                   |  |                         |  |
| Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item                                                                                                                                             |    |                                                                         |                                                                                            |                               |  |                   |  |                         |  |
| Mark "X" in appropriate box for COS and/or R                                                                                                                                                                               |    |                                                                         |                                                                                            |                               |  |                   |  |                         |  |
| IN= in compliance    OUT= not in compliance    N/O= not observed    N/A= not applicable    COS=corrected on-site during inspection    R= repeat violation                                                                  |    |                                                                         |                                                                                            |                               |  |                   |  |                         |  |
| Compliance Status                                                                                                                                                                                                          |    |                                                                         |                                                                                            | COS                           |  | R                 |  |                         |  |
| Supervision                                                                                                                                                                                                                |    |                                                                         |                                                                                            |                               |  |                   |  |                         |  |
| 1                                                                                                                                                                                                                          | IN | OUT                                                                     | PIC knowledgeable; duties & oversight                                                      |                               |  |                   |  |                         |  |
| 2                                                                                                                                                                                                                          | IN | OUT N/A                                                                 | Certified food protection manager, duties                                                  |                               |  |                   |  |                         |  |
| Employee Health                                                                                                                                                                                                            |    |                                                                         |                                                                                            |                               |  |                   |  |                         |  |
| 3                                                                                                                                                                                                                          | IN | OUT                                                                     | Mgmt/Staff;knowledge,responsibilities&reporting                                            |                               |  |                   |  |                         |  |
| 4                                                                                                                                                                                                                          | IN | OUT                                                                     | Proper use of reporting, restriction & exclusion                                           |                               |  |                   |  |                         |  |
| 5                                                                                                                                                                                                                          | IN | OUT                                                                     | Procedures for responding to vomiting & diarrheal events                                   |                               |  |                   |  |                         |  |
| Good Hygienic Practices                                                                                                                                                                                                    |    |                                                                         |                                                                                            |                               |  |                   |  |                         |  |
| 6                                                                                                                                                                                                                          | IN | OUT N/O                                                                 | Proper eating, tasting, drinking, or tobacco use                                           |                               |  |                   |  |                         |  |
| 7                                                                                                                                                                                                                          | IN | OUT N/O                                                                 | No discharge from eyes, nose, & mouth                                                      |                               |  |                   |  |                         |  |
| Preventing Contamination by Hands                                                                                                                                                                                          |    |                                                                         |                                                                                            |                               |  |                   |  |                         |  |
| 8                                                                                                                                                                                                                          | IN | OUT N/O                                                                 | Hands clean & properly washed                                                              |                               |  |                   |  |                         |  |
| 9                                                                                                                                                                                                                          | IN | OUT N/A N/O                                                             | No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed |                               |  |                   |  |                         |  |
| 10                                                                                                                                                                                                                         | IN | OUT                                                                     | Adequate handwashing sinks supplied/accessible                                             |                               |  |                   |  |                         |  |
| Approved Source                                                                                                                                                                                                            |    |                                                                         |                                                                                            |                               |  |                   |  |                         |  |
| 11                                                                                                                                                                                                                         | IN | OUT                                                                     | Food obtained from approved source                                                         |                               |  |                   |  |                         |  |
| 12                                                                                                                                                                                                                         | IN | OUT N/A N/O                                                             | Food received at proper temperature                                                        |                               |  |                   |  |                         |  |
| 13                                                                                                                                                                                                                         | IN | OUT                                                                     | Food in good condition, safe, & unadulterated                                              |                               |  |                   |  |                         |  |
| 14                                                                                                                                                                                                                         | IN | OUT N/A N/O                                                             | Required records available; shellstock tags, parasite destruction                          |                               |  |                   |  |                         |  |
| Protection from Contamination                                                                                                                                                                                              |    |                                                                         |                                                                                            |                               |  |                   |  |                         |  |
| 15                                                                                                                                                                                                                         | IN | OUT N/A N/O                                                             | Food separated and protected                                                               |                               |  |                   |  |                         |  |
| 16                                                                                                                                                                                                                         | IN | OUT N/A                                                                 | Food contact surfaces: cleaned & sanitized                                                 |                               |  |                   |  |                         |  |
| 17                                                                                                                                                                                                                         | IN | OUT                                                                     | Proper disposition of returned, previously served, reconditioned, & unsafe food            |                               |  |                   |  |                         |  |
| GOOD RETAIL PRACTICES                                                                                                                                                                                                      |    |                                                                         |                                                                                            |                               |  |                   |  |                         |  |
| Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.                                                                                          |    |                                                                         |                                                                                            |                               |  |                   |  |                         |  |
| Mark "X" in box if numbered item is not in compliance    Mark "X" in appropriate box for COS and/or R    COS=corrected on-site during inspection    R= repeat violation                                                    |    |                                                                         |                                                                                            |                               |  |                   |  |                         |  |
|                                                                                                                                                                                                                            |    |                                                                         |                                                                                            | COS                           |  | R                 |  |                         |  |
| Safe Food and Water                                                                                                                                                                                                        |    |                                                                         |                                                                                            |                               |  |                   |  |                         |  |
| 30                                                                                                                                                                                                                         | IN | OUT N/A                                                                 | Pasteurized eggs used where required                                                       |                               |  |                   |  |                         |  |
| 31                                                                                                                                                                                                                         |    | Water & ice obtained from an approved source                            |                                                                                            |                               |  |                   |  |                         |  |
| 32                                                                                                                                                                                                                         | IN | OUT N/A                                                                 | Variance obtained for specialized processing methods                                       |                               |  |                   |  |                         |  |
| Food Temperature Control                                                                                                                                                                                                   |    |                                                                         |                                                                                            |                               |  |                   |  |                         |  |
| 33                                                                                                                                                                                                                         |    | Proper cooling methods used; adequate equipment for temperature control |                                                                                            |                               |  |                   |  |                         |  |
| 34                                                                                                                                                                                                                         | IN | OUT N/A N/O                                                             | Plant food properly cooked for hot holding                                                 |                               |  |                   |  |                         |  |
| 35                                                                                                                                                                                                                         | IN | OUT N/A N/O                                                             | Approved thawing methods used                                                              |                               |  |                   |  |                         |  |
| 36                                                                                                                                                                                                                         |    | Thermometers provided & accurate                                        |                                                                                            |                               |  |                   |  |                         |  |
| Food Identification                                                                                                                                                                                                        |    |                                                                         |                                                                                            |                               |  |                   |  |                         |  |
| 37                                                                                                                                                                                                                         |    | Food properly labeled; original container                               |                                                                                            |                               |  |                   |  |                         |  |
| Prevention of Food Contamination                                                                                                                                                                                           |    |                                                                         |                                                                                            |                               |  |                   |  |                         |  |
| 38                                                                                                                                                                                                                         |    | Insects, rodents, & animals not present                                 |                                                                                            |                               |  |                   |  |                         |  |
| 39                                                                                                                                                                                                                         |    | Contamination prevented during food prep, storage & display             |                                                                                            |                               |  |                   |  |                         |  |
| 40                                                                                                                                                                                                                         |    | Personal cleanliness                                                    |                                                                                            |                               |  |                   |  |                         |  |
| 41                                                                                                                                                                                                                         |    | Wiping cloths: properly used & stored                                   |                                                                                            |                               |  |                   |  |                         |  |
| 42                                                                                                                                                                                                                         |    | Washing fruits & vegetables                                             |                                                                                            |                               |  |                   |  |                         |  |
| Food Recalls:                                                                                                                                                                                                              |    |                                                                         |                                                                                            |                               |  |                   |  |                         |  |
| Person in Charge (Signature)                                                                                                                                                                                               |    |                                                                         |                                                                                            |                               |  |                   |  |                         |  |
| Date: 07/08/24                                                                                                                                                                                                             |    |                                                                         |                                                                                            |                               |  |                   |  |                         |  |
| Inspector (Signature)                                                                                                                                                                                                      |    |                                                                         |                                                                                            |                               |  |                   |  |                         |  |