Electronically Delivered

December 18, 2023

Licensee
Derman Senior Care, Inc.
2401 Williams Drive
Burnsville, MN 55337

RE: Project Number(s) SL36147015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on December 5, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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 the 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/HRD-Appeals-Form

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

If you have any questions, please contact me.

Sincerely,

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

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36147	A. BUILDING: _____ B. WING _____	12/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DERMAN SENIOR CARE INC	2401 WILLIAMS DR BURNSVILLE, MN 55337

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL36147015-0 On December 4, 2023, through December 5, 2023, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were two active residents; two receiving services under the Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 470 SS=C	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that:	0 470		

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0 470	Continued From page 1 (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the staffing schedule was posted as required, potentially affecting the licensee's current residents and any visitors. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive	0 470		

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0 470	Continued From page 2 or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee lacked a daily staffing schedule developed by the clinical nurse supervisor per Assisted Living Facilities: Minnesota Rules Chapter 4659.0180 Subp. 4. to: - include direct-care staff work schedules for each direct-care staff member showing all work shifts, including days and hours worked; - identify the direct-care staff member's resident assignments or work location; and - be posted after redacting direct-care staff member's resident assignments, at the beginning of each work shift in a central location in each building. On December 4, 2023, at 1:26 p.m. during the facility tour the surveyor observed the main entry area and resident common areas of the building, there was no staff schedule observed. Unlicensed personnel/licensed assisted living director in residence (ULP/LALDIR)-C stated the daily schedule was posted inside the locked medication cupboard and downstairs inside of the office for staff to view, but it was not accessible to residents, volunteers, or visitors. The licensee's Staffing policy dated January 7, 2022, noted the schedule is posted at the beginning of the shift in a central location in each building, if applicable, accessible to staff, residents, volunteers, and the public. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One	0 470		

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0 470	Continued From page 3 (21) days	0 470		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated December 5, 2023, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place	0 550		

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0 550	Continued From page 4 information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post in a conspicuous place, information about the licensee's grievance procedure with the required content. This had the potential to affect the licensee's current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On December 4, 2023, at 1:26 p.m. during the facility tour, the surveyor observed the main entry	0 550		

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0 550	Continued From page 5 area and resident common areas of the building. On the living room wall with other required postings, were blank grievance forms and an envelope to drop them into. Though there were blank grievance forms available, there was no posted facility grievance procedure to include the name, telephone number, and e-mail contact information for the individuals responsible for handling resident complaints. In addition, the contact information for the Office of Ombudsman for Long-Term Care (OOLTC) and the Office of Ombudsman for Mental Health and Developmental Disabilities (OOMHDD) was missing. On December 4, 2023, at 3:00 p.m. unlicensed personnel/licensed assisted living director in residence (ULP/LALDIR)-C stated the content noted above was not posted as required. The licensee's Grievance policy dated January 7, 2022, identified the following: 2. A copy of the grievance procedure is conspicuously posted in the residence with the following information: -name, phone number and email contact information for the individuals who are responsible for handling resident complaints; -contact information for the state and any regional Office of Ombudsman for Long-Term-Care; -contact information for the Office of Ombudsman for Mental Health and Developmental Disabilities; -contact information for the Minnesota Adult Abuse Reporting Center. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	0 550		

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0 550	Continued From page 6 (21) days	0 550		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to post emergency exit diagrams in the required areas on each floor, have a written EP plan with all the required content, practice, and document testing of its emergency preparedness (EP) plan at least twice annually as	0 680		

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0 680	Continued From page 7 required and evaluate its missing person policy at least quarterly per Assisted Living Facilities: Minnesota Rules Chapter 4659. This had the potential to affect all residents, staff, and visitors of the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: EMERGENCY EXIT DIAGRAMS On December 4, 2023, at 1:26 p.m. during the facility tour, the surveyor observed no emergency exit diagrams in the hallways or resident common areas of the licensee's basement, main floor, or upper floors of the building. EMERGENCY PREPAREDNESS PLAN CONTENT The licensee's emergency preparedness plan consisted of several documents and policies in a red three-ringed binder dated as reviewed August 24, 2023. The book included a risk assessment, a communication plan, and various policies/procedures. The licensee's plan lacked the following required content: -Policy/procedure to address subsistence needs for staff and residents during an emergency to include (food, water, medical supplies, pharmacy supplies, sewer and waste disposal, emergency lighting, fire detection, extinguishing and alarm	0 680		

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0 680	Continued From page 8 systems); -Policy/procedures for sharing information on occupancy/needs, and its ability to provide assistance. EP PLAN TESTING The EP plan lacked evidence the facility had tested its EP plan, conducted and/or participated in a full-scale community-based exercise, or conducted a tabletop exercise to test its plan and document the results of testing at least twice annually as required. MISSING RESIDENT PLAN/POLICY The licensee's undated, Missing Resident policy was included in the EP plan. The policy lacked evidence the assisted living director and clinical registered nurse reviewed or updated the policy and documented any changes, at least quarterly as required per Assisted Living Facilities: Minnesota Rules Chapter 4659.0110 Subp. 4. On December 5, 2023, at 2:45 p.m. unlicensed personnel/licensed assisted living director in residence (ULP/LALDIR)-C stated the licensee's EP plan lacked the above required components. The licensee's Emergency Preparedness policy dated January 7, 2022, identified the emergency disaster plan is prominently posted on each floor and includes: - a schematic plan of the facility or portions of the facility that shows emergency exit diagrams. In addition, the policy included [The Licensee] would have an identified plan in place to assure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupts services. The policy included reference to Centers for Medicare and Medicaid Services (CMS) State Operations Manual Appendix Z;	0 680		

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0 680	Continued From page 9 Minnesota (MN) Rules 4659.0100. The licensee's Missing Resident policy dated January 7, 2022, noted the missing resident procedure will be reviewed by the Director and Clinical Nurse Supervisor at least quarterly. Changes to the plan will be documented. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to	0 810		

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0 810	Continued From page 10 include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required training and drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On December 5, 2023, unlicensed personnel/licensed assisted living director in residence (ULP/LALDIR)-C provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The licensee FSEP, titled "Fire Safety", undated,	0 810		

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0 810	Continued From page 11 failed to include the following: The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan included the acronym R.A.C.E. (Remove, Alarm, Confine and Extinguish or Evacuate) but failed to include procedures for how staff are to complete each step. The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures residents should follow in case of a fire or similar emergency. The FSEP included standard resident evacuation procedures but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan included instructions to evacuate residents but did not include any procedures for assisting residents during evacuation nor did it include instructions for staff to follow in case of relocation. During an interview on December 5, 2023, at 1:00 p.m., ULP/LALDIR-C stated she understood the areas of her policy that were incomplete and would work on bringing them into compliance. TRAINING Record review indicated the licensee failed to provide training to employees on the FSEP upon hire and at least twice per year as evidenced by the report for the one in-person staff training on the facility-specific plan that was completed on	0 810		

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0 810	Continued From page 12 08/25/2023. No other documentation was provided. During an interview on December 5, 2023, at 1:00 p.m., ULP/LALDIR-C stated she understood the areas of her training that were insufficient and would work on bringing them into compliance. DRILLS 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 evidenced by the fire drill log provided. An evacuation drill was conducted on 04/17/2023. No other documentation was provided. During an interview on December 5, 2023, at 1:00 p.m., ULP/LALDIR-C stated there were no further documented drills for the facility and verified this deficient condition. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01290 SS=D	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith	01290		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DERMAN SENIOR CARE INC	2401 WILLIAMS DR BURNSVILLE, MN 55337

(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
01290	Continued From page 13 reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a background study was submitted and received in affiliation with the assisted living license for one of one employee (unlicensed personnel (ULP)-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-D was hired on October 21, 2022, to provide direct care and services to the licensee's residents. On December 5, 2023, at 9:30 a.m., the surveyor observed ULP-D administer medications to R3. ULP-D's employee record contained a background study dated June 20, 2021, for a separate location operated by the licensee's owner. ULP-D's employee record lacked evidence the licensee affiliated a background study for their license. On December 5, 2023, at 10:05 a.m., unlicensed	01290		

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01290	Continued From page 14 personnel/licensed assisted living director in residence (ULP/LALDIR)-C stated ULP-D's background study had not been affiliated with the assisted living facility license. The licensee's Recruitment and Hiring policy dated January 7, 2022, noted a criminal background check will be submitted to Minnesota Department of Human Services (DHS) following the step-by-step procedure established by DHS. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01540 SS=F	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED (3) for assisted living facilities with dementia care, direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced	01540		

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01540	Continued From page 15 by: Based on interview and record review, the licensee failed to ensure one of one employee (unlicensed personnel (ULP)-D) completed the required amount of dementia care training in the required time frame. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-D had a hire date of October 21, 2022, to provide direct care services under the licensee's assisted living license. ULP-D's employee record contained evidence of five hours of training on dementia care topics, instead of the required eight hours. On December 5, 2023, at 10:05 a.m. unlicensed personnel/licensed assisted living director in residence (ULP/LALDIR)-C stated the dementia training was auto assigned through their online Educare program. ULP/LALDIR-C stated employees only have five hours assigned to them and was not aware of the eight hours as required. ULP/LALDIR-C stated none of the licensee's employees would have the required eight hours of dementia training. ULP/LALDIR-C further verified ULP-D had worked greater than 160 hours. The licensee's Dementia Education policy dated	01540		

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01540	Continued From page 16 January 7, 2022, noted direct care employees must have completed at least eight (8) hours of initial education within 160 working hours of the employment start date. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01540		
01610 SS=D	144G.70 Subd. 2 (a-b) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a registered nurse (RN) conducted an initial assessment for one of one resident (R1) prior to initiation of services.	01610		

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01610	Continued From page 17 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was admitted on September 26, 2022, and received services under the licensee's assisted living license. R1 had a diagnosis of vascular neurocognitive disease (disrupted blood flow to the brain and causes problems with reasoning, planning, judgement, and memory). R1's Service Plan (Waiver)- Addendum to Contract dated February 23, 2023, indicated R1 received assistance with medication administration, bathing reminder, laundry, and housekeeping. R1's record included an Admission Assessment dated October 2, 2022. No assessment was completed prior to or upon initiation of services on September 26, 2022. On December 5, 2023, at 11:45 a.m. clinical nurse supervisor (CNS)-B stated R1's admission assessment was not completed when required. The licensee's Assessment and Reassessment policy dated January 7, 2022, noted the initial registered nurse assessment shall be completed prior to the date on which the prospective	01610		

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01610	Continued From page 18 resident executes a contract or on the date on which the prospective resident moves in, whichever is earlier. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01610		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by:	01620		

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01620	Continued From page 19 Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed a reassessment not to exceed 90 days for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's Service Plan (Waiver)- Addendum to Contract dated February 23, 2023, indicated R1 received assistance with medication administration, bathing reminder, laundry, and housekeeping. R1's last two assessments dated June 24, 2023, and September 24, 2023, were provided. 92 days had passed between assessments (two days late) exceeding 90 calendar days. On December 5, 2023, at 11:45 a.m. clinical nurse supervisor (CNS)-B stated R1's assessment was conducted after the 90-day requirement. The licensee's Assessment and Reassessment policy dated January 7, 2022, identified on-going resident reassessments must be conducted by a registered nurse (RN) and cannot exceed 90 days from the last date of assessment. No further information was provided.	01620		

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01620	Continued From page 20 TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
01700 SS=D	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the	01700		

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01700	Continued From page 21 registered nurse (RN) conducted a face-to-face medication management assessment to include all required content for one of one resident (R1) prior to providing medication management services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on December 4, 2023, at 11:15 a.m. clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to their residents. R1 had a diagnosis of vascular neurocognitive disease (disrupted blood flow to the brain and causes problems with reasoning, planning, judgement, and memory). R1's Service Plan (Waiver)- Addendum to Contract dated February 23, 2023, indicated R1 received assistance with medication administration. R1's prescriber orders dated October 12, 2023, included two for blood pressure, one for heart health, one for acid reflux, one for prostate enlargement, and one supplement. On December 5, 2023, at 3:15 p.m. unlicensed personnel/licensed assisted living director in	01700		

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01700	Continued From page 22 residence (ULP/LALDIR)-C was observed to administer medications to R1. R1 began receiving services from the licensee on September 26, 2022. R1's record indicated a medication management assessment was completed on October 2, 2022, (six days after the start of services). On December 5, 2023, at 11:45 a.m. CNS-B stated R1 began receiving medication administration services on September 26, 2022. CNS-B further stated a medication management assessment with all required components, had not been completed until the resident's late admission assessment on October 2, 2022. The licensee's Assessment of Medications policy dated January 7, 2022, identified prior to providing medication management services, [The Licensee] would provide an assessment by a registered nurse (RN) to determine what medication management services would be provided and how they would be implemented. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01700		
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current	01730		

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01730	Continued From page 23 individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) developed an	01730		

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01730	Continued From page 24 individualized medication management record to include all required content for one of one resident (R1) prior to providing medication management services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on December 4, 2023, at 11:15 a.m. clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to their residents. R1 had a diagnosis of vascular neurocognitive disease (disrupted blood flow to the brain and causes problems with reasoning, planning, judgement, and memory). R1's Service Plan (Waiver)- Addendum to Contract dated February 23, 2023, indicated R1 received assistance with medication administration. R1's prescriber orders dated October 12, 2023, included two for blood pressure, one for heart health, one for acid reflux, one for prostate enlargement, and one supplement. On December 5, 2023, at 3:15 p.m. unlicensed personnel/licensed assisted living director in residence (ULP/LALDIR)-C was observed to	01730		

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01730	Continued From page 25 administer medications to R1. R1 began receiving services from the licensee on September 26, 2022. R1's record indicated a medication management plan was completed on October 2, 2022, (six days after the start of services). On December 5, 2023, at 11:45 a.m. CNS-B stated R1 began receiving medication administration services on September 26, 2022. CNS-B further stated a medication management plan with all required components, had not been completed until the resident's late admission assessment on October 2, 2022. The licensee's Assessment of Medications policy dated January 7, 2022, identified prior to providing medication management services, [The Licensee] would provide an assessment by a registered nurse (RN) to determine what medication management services would be provided and how they would be implemented. Based on the results of the assessment, the RN would document an individualized medication management plan, including the following elements: -Description of medication management services to be provided; -Description of medication storage based on resident need, preference, risk of diversion and per manufacturer's direction; -Documentation procedures; -Procedures for verification that medications are administered as prescribed; -Procedures for monitoring medication use to prevent complications or adverse reactions; -Identification of person(s) responsible for monitoring medication supplies and ensuring refills are ordered in a timely manner;	01730		

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01730	Continued From page 26 -Identification of medication management tasks delegated to unlicensed staff; -Procedures for notifying the registered nurse or licensed health profession regarding problems arising with medication management services; No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01770 SS=F	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure documentation of medication setup included all the required content for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: R1's record lacked documentation by the licensed	01770		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DERMAN SENIOR CARE INC	2401 WILLIAMS DR BURNSVILLE, MN 55337

(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
01770	Continued From page 27 nurse at the time of each weekly setup to include the name of medication, quantity of dose, times to be administered, and route of administration. During the entrance conference on December 4, 2023, at 11:15 a.m. clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to their residents, including medication setup. R1's Service Plan (Waiver)- Addendum to Contract dated February 23, 2023, indicated R1 received assistance with medication administration. R1's service plan did not include medication setup. R1's prescriber orders dated October 12, 2023, included two for blood pressure, one for heart health, one for acid reflux, one for prostate enlargement, and one supplement. On December 5, 2023, at 9:53 a.m. clinical nurse supervisor (CNS)-B stated he completed a weekly medication set up for both R1 and R3 to make it easier for the unlicensed personnel (ULP) administering the medications. CNS-B stated he documented the medication set up on the electronic medication administration record (eMAR); however, the computer software program only allowed the set up to be documented once a month. CNS-B stated he did not document weekly for each set up of medications for anyone getting a medication set up. CNS-B indicated he would need to contact the computer software program to see if there was another way to document the medication set up. The licensee's Medication Documentation policy dated January 7, 2022, identified [The Licensee]	01770		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36147	A. BUILDING: _____ B. WING _____	12/05/2023

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01770	Continued From page 28 would document medication set up according to the following: a. date of medication setup b. name of medication c. quantity of dose d. times to be administered e. route of administration f. name/title of person completing medication setup No further information was provided. TIME PERIOD TO CORRECT: Seven (7) Days	01770		

Minnesota Department of Health
Environmental Health, FPLS
P.O Box 64975
Saint Paul
651-201-4500

Type: Full
Date: *12/05/23*
Time: 15:28:52
Report: 1018231222

Food and Beverage Establishment Inspection Report

Location:
Derman Senior Care Inc
2401 Williams Dr
Burnsville, MN55337
Dakota County, 19

Establishment Info:
ID #: 0039115
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6125174611
ID #:

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

The following orders were issued during this inspection.

2-100 Supervision

2-102.12AMN

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

NO CERTIFIED FOOD PROTECTION MANAGER CERTIFICATE ON SITE. APPLICATION PROVIDED TO MANAGER WITH REPORT.

Comply By: 05/31/24

Surface and Equipment Sanitizers

Chlorine: = 100PPM at Degrees Fahrenheit
Location: SPRAY
Violation Issued: No

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

ESTABLISHMENT IS A RESIDENTIAL HOME WITH ALL RESIDENTIAL EQUIPMENT.

ALL FOOD IS PREPARED FOR SAME DAY AND NO COOLING HAPPENS IN THE FACILITY.

DISHWASHER IS CURRENTLY OUT OF ORDER AND SO ESTABLISHMENT IS USING A 3 BUCKET SYSTEM TO SANITIZE DISHES.

FLOORS, WALLS, CEILINGS AND EQUIPMENT ARE ALL RESIDENTIAL AND WILL BE MONITORED THROUGH THE YEARS.

DISCUSSED EMPLOYEE ILLNESS, ILLNESS REPORTING AND PEST CONTROL.

Food and Beverage Establishment Inspection Report

ESTABLISHMENT HAS 2 BASIN HAND SINK WITH ONE SIDE DESIGNATED FOR HAND WASHING ONLY.

NO TEMPERATURES WERE RECORDED DURING THIS INSPECTION AS THE ESTABLISHMENT WAS RECEIVING A NEW REFRIGERATOR AT THE TIME.

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 1018231222 of 12/05/23.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/ /_____

Inspection report reviewed with person in charge and emailed.

Signed:_____
Establishment Representative

Signed:_____
Rebecca Prestwood
Sanitarian 3
6512013777
rebecca.prestwood@state.mn.us