DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

January 4, 2023

Licensee
Living Well Home Care
5019 61st Avenue North
Brooklyn Center, MN 55429

RE: Project Number(s) SL37939015

Dear Licensee:

On December 29, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine if orders from the June 2, 2022, evaluation were corrected. This follow-up evaluation verified that the facility is in substantial compliance.

It is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body. You are encouraged to retain this document for your records.

Please feel free to call me with any questions.

Sincerely,

Paul T. Spencer

Paul Spencer, Supervisor
State Rapid Response Team
85 East Seventh Place, Suite 220
P.O. Box 64970
St. Paul, MN 55164-0970
Telephone: 651-201-4222 Fax: 651-281-9796

PMB

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF REMOVAL OF CONDITIONAL LICENSE
ASSISTED LIVING FACILITY LICENSE GRANTED

Electronic Delivery

December 12, 2022

Administrator
Living Well Home Care, LLC
5019 61st Avenue North
Brooklyn Center, MN 55429

RE: Conditional License Number 405023
Health Facility Identification Number (HFID) 37939
Project Number(s) SL37939015

Dear Administrator:

On November 21, 2022, The Minnesota Department of Health (MDH) completed a follow-up evaluation of your facility to determine correction of orders found on the licensing evaluation completed June 2, 2022. The follow-up evaluation found the facility to be in substantial compliance. Based on these findings, the condition(s) on the license were removed effective November 30, 2022.

Effective November 30, 2022, MDH is granting your Assisted Living Facility facility license. Your Provisional Assisted Living Facility (PALF) license expired on July 31, 2022. Your PALF license was extended with conditions to November 30, 2022. Your license number is 405023. If you have not received a letter from us with information regarding renewing your license within 45 days, please contact us at (651) 201-5273 or by email at: Health.Homecare@state.mn.us.

Furthermore, The follow-up evaluation determined your facility had not corrected all of the state licensing orders issued pursuant to the initial evaluation.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a), state licensing orders issued pursuant to the last evaluation completed on June 2, 2022, found not corrected at the time of the November 21, 2022, follow-up evaluation and subject to a penalty assessment are as follows:

0660-Tuberculosis Prevention And Control-144g.42 Subd. 9 = $500
0680-Disaster Planning And Emergency Preparedness-144g.42 Subd. 10 = $500
1480-Orientation To Resident-144g.63 Subd. 3 + $500
1540-Training In Dementia Care Required-144g.64 (a) = $500
1640-Service Plan, Implementation And Revisions To-144g.70 Subd. 4 (a-E) = $500

The details of the violations noted at the time of this follow-up evaluation completed on November 21,

2022 (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 $2,500**. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

Also, at the time of this follow-up evaluation completed on November 21, 2022, we identified the following violation(s):

1290-Background Studies Required-144g.60 Subdivision 1
1460-Orientation Of Staff And Supervisors-144g.63 Subdivision 1

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

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144G.30, Subd. 5(c), by the correction order date, the licensee must document in the provider's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the assisted living facility's action to respond to the correction orders in future evaluations, upon a complaint evaluation, and as otherwise needed. The licensee is not required to submit a plan of correction 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).

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 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 Department of Health within 15 calendar days of the correction order receipt date. Please email general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

Please address your cover letter for general reconsideration requests to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

Free from Maltreatment reconsideration requests should addressed to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. Requests for hearing may be emailed to **Health.HRD.Appeals@state.mn.us**.

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact Paul Spencer, Supervisor, at 651-201-4222.

Sincerely,

Maria King

Maria King, RN
Division Director

Minnesota Department of Health
Health Regulation Division

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37939	A. BUILDING: _____ B. WING _____	R 11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVING WELL HOME CARE	5019 61ST AVENUE NORTH BROOKLYN CENTER, MN 55429

(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 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: SL#37939015 On November 21, 2022, the Minnesota Department of Health conducted a licening order follow-up survey at the above provider, and the following immediate correction orders is issued at 1290. There may be additional non-immediate orders issued at a later date. ---------- ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section	{0 000}	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	

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{0 000}	Continued From page 1 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: SL#37939015 On November 21,2022, the Minnesota Department of Health conducted a licensing order follow-up at the above provider, and the following correction orders are issued. At the time of the survey, there were ----- residents under the Assisted Living license. The following correction orders are reissued: 660, 680, 1460, 1480, 1540 and 1640.	{0 000}		
{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: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according	{0 480}		

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{0 480}	Continued From page 2 to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Not assessed	{0 480}		
{0 660} SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (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. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to establish and maintain a comprehensive tuberculosis (TB) infection control prevention program according to the most current guidelines issued by the Centers for Disease Control (CDC), including a baseline TB screening for two of three new employees ((unlicensed	{0 660}		

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{0 660}	Continued From page 3 personnel (ULP)-I and register nurse (RN)-J)) with records reviewed. This had the potential to affect all three residents receiving assisted living services, as well as 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 the potential to affect a large portion or all the residents). The findings include: ULP-I ULP-I was hired on October 8, 2022. ULP-I's employee record lacked evidence of a Baseline TB Screening Tool. RN-J RN-J was hired on October 1, 2022. RN-J's employee record lacked evidence of a Baseline TB Screening Tool. During an interview on November 21, 2022, at 1:30 p.m., licensed assisted living director (LALD-A) verified ULP-I and RN-J employee records were missing a TB Screening Tool. The licensee provided Tuberculosis Screening Policy dated August 1, 2021, indicated new staff would be screened for active signs of TB using the Baseline TB Screening Tool for healthcare workers.	{0 660}		

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{0 680}	Continued From page 4	{0 680}		
{0 680} SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant 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 document review, the licensee failed to develop a complete emergency disaster plan with all the required content, provide initial and annual staff training, and make annual training available to residents. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a	{0 680}		

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{0 680}	Continued From page 5 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: Review of the licensee provided Emergency Preparedness Policy, dated October 17, 2022, indicated the licensee would have an identified plan in place to assure safety and well-being of resident and staff during periods of emergency or disaster. The policy also indicated the licensee would implement the Emergency Management program as soon as the agency became aware of the existence of an emergency. Review of the licensee provided Emergency Preparedness Manual included a page to indicate when the licensee program/policies were established, the page was blank. The licensee's plan lacked the following required content: - process for EP cooperation with state and local EP officials/organizations. - a thoroughly completed risk assessment; - arrangements/contracts to re-establish utility services; and - a description of the population served by the licensee. - development of policies/procedures to address: - procedure for tracking staff and residents; - subsistence needs for staff and residents during an emergency; - shelter in place; - a medical record documentation system to preserve resident information, security, and	{0 680}		

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{0 680}	Continued From page 6 availability; - emergency staffing strategies to include volunteers; - development of arrangements with other facilities and providers to receive residents if needed; and - the facilities role in providing care and treatment at alternative sites. - a communication plan that included: - arrangement with other facilities; - names and contact information for staff, resident physicians, other facilities; - primary and alternative means for communicating with facility staff, federal, state, regional and local emergency management agencies; - a method of sharing information and medical documentation for residents; and - a means to provide information regarding the facility's needs, and its ability to provide assistance to include information about their occupancy. - emergency preparedness training and documentation of training During an interview on November 21, 2022, at 2:30 p.m., licensed assisted living director (LALD-A) stated the licensee's Disaster Planning and Emergency Preparedness Plan was provided to them by Home Care Consultants LALD-A confirmed he had not read the entire binder. When asked if the licensee has done education with staff and residents, LALD stated they had educated on fire drills and associated evacuations. LALD-A stated he has a verbal agreement with another assisted living facility nearby for relocation but nothing in writing.	{0 680}		

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{0 780}	Continued From page 7	{0 780}		
{0 780} SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (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 (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; This MN Requirement is not met as evidenced by: Not assessed	{0 780}		
{0 800} SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the	{0 800}		

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{0 800}	Continued From page 8 health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Not assessed	{0 800}		
{0 810} SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one	{0 810}		

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{0 810}	Continued From page 9 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: Not assessed	{0 810}		
01290 SS=F	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 reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a background study was completed prior to staff providing services for two of nine employees (unlicensed personnel (ULP-H, ULP-I) with records reviewed. This resulted in an immediate correction order on November 22, 2022, at approximately 4:00 p.m. This practice resulted in a level two violation (a	01290		

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01290	Continued From page 10	01290		

violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).

The findings include:

ULP-H was hired on October 8, 2022. ULP-H's employee record lacked evidence a background study had been completed prior to providing care and services.

The licensee's daily staffing schedule indicated ULP-H worked 6:00 p.m. to 6:00 a.m. on November 5th, 6th, 19th, and 20th.

ULP-I was hired on October 8, 2022. ULP-I's employee record lacked evidence a background study had been completed prior to providing care and services.

The licensee's daily staffing schedule indicated ULP-H worked 6:00 p.m. to 6:00 a.m. on November 12th, and 13th.

On November 21, 2022, at 1:45 p.m., LALD-A stated background studies were completed on all employees. LALD-A stated the rest of ULP-H and ULP-I's paperwork must be at the office, and he could email it to the surveyor.

On November 22, 2022, the surveyor reviewed the Netstudy website and determined neither ULP-H or ULP-I were cleared to work. The website indicated licensed assisted living director (LALD-A) received a letter dated November 12, 2022, stating ULP-H had not provided fingerprints

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	37939	A. BUILDING: _____ B. WING _____	R 11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVING WELL HOME CARE	5019 61ST AVENUE NORTH BROOKLYN CENTER, MN 55429

(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 11 and a photo in the time required and was to be removed from her position immediately. The website also indicated ULP-I had not been previously determined eligible for employment and must be fingerprinted by November 24, 2022. The licensee-provided policy titled Recruitment and Hiring, dated October 17, 2022, indicated NetStudy 2.0 would be used for background checks and the employee will be directed to locations established by DHS to obtain fingerprint scans. TIME PERIOD FOR CORRECTION: IMMEDIATE	01290		
01460 SS=F	144G.63 Subdivision 1 Orientation of staff and supervisors All staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. The orientation may be incorporated into the training required under subdivision 5. The orientation need only be completed once for each staff person and is not transferable to another facility. This MN Requirement is not met as evidenced by: Based on record review, and interview, the licensee failed to ensure one of three new employees, registered nurse (RN)-J, received orientation to the facility or assisted living licensing requirements and regulations with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or	01460		

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01460	Continued From page 12	01460		

safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally).

The findings include:

RN-J was hired on October 1, 2022.

RN-J's employee record lacked evidence indicating the employee received facility orientation or 144G assisted living licensing requirements and regulations orientation to include the following topics prior to providing assisted living services:
- an overview of this chapter [144G]
- an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person.
- handling of emergencies and use of emergency services.
- the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights.
- the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person.
- handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints.
- consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or

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01460	Continued From page 13 other relevant advocacy services; and - a review of the types of assisted living services the employee will be providing and the facility's category of licensure During an interview on November 21, 2022, at 1:30 p.m., the licensed assisted living director (LALD-A) stated he did not know RN-J had to complete the same orientation and training as the unlicensed employees. The licensee provided Orientation & Training Policy dated August 1, 2021, indicated the licensee would maintain records of required training and competency for staff.	01460		
{01480} SS=F	144G.63 Subd. 3 Orientation to resident Staff providing assisted living services must be oriented specifically to each individual resident and the services to be provided. This orientation may be provided in person, orally, in writing, or electronically. This MN Requirement is not met as evidenced by: Based on record review, and interview, the licensee failed to ensure staff providing assisted living services were oriented specifically to each individual resident and the services to be provided for one of three new employees, registered nurse (RN)-J, with records reviewed. 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	{01480}		

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{01480}	Continued From page 14 problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: RN-J was hired on October 1, 2022. RN-J's employee record lacked evidence that RN-J received resident specific orientation. During an interview on November 21, 2022, at 1:30 p.m., the licensed assisted living director (LALD-A) stated he did not know RN-J had to complete the same orientation and training as the other staff employees. The licensee provided Orientation & Training Policy dated August 1, 2021, indicated the licensee would maintain records of required training and competency for staff.	{01480}		
{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	{01540}		

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{01540}	Continued From page 15 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 by: Based on document review and interview, the licensee failed to ensure staff received the required amount of dementia care training in the required period for one of three new employees, registered nurse (RN)-J, with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: RN-J was hired on October 1, 2022. RN-J's employee record lacked evidence that RN-J received the required dementia training. During an interview on November 21, 2022, at 1:30 p.m., the licensed assisted living director (LALD-A) stated he did not know RN-J had to complete the same orientation and training as the other staff employees. The licensee provided Orientation & Training Policy dated August 1, 2021, indicated the licensee would maintain records of required training and competency for staff.	{01540}		

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{01640}	Continued From page 16	{01640}		
{01640} SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on document review and interview, the licensee failed to ensure all residents had a registered nurse (RN) complete a comprehensive assessment to include all areas identified on the uniform assessment tool for one of one resident (R1) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a residents health or safety but had the potential to have harmed a	{01640}		

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{01640}	Continued From page 17 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: Review of R1's medical record on November 21, 2022 at 11:30 a.m. included a paper copy of R1's service plan which failed to include signatures from the resident or resident's representative. During an interview on November 21, 2022 at 11:30 a.m., licensed assisted living director (LALD-A) stated he was not sure why it was not signed and would have the resident sign the service plan right away. The surveyor made a request to receive a copy of the service plan prior to signatures, but it was not recieved until after signatures were added. The licensee-provided Service Plan Policy dated August 1, 2021, indicated the service plan and any revisions shall include a signature or other authentication by Living Well Home Care and by the resident, or resident's representative, documenting agreement on the services to be provided.	{01640}		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF EXTENSION OF PROVISIONAL LICENSE
CONDITIONAL LICENSE ISSUED

Electronically delivered

September 1, 2022

Administrator
Living Well Home Care, LLC
5019 61st Avenue North
Brooklyn Center, MN 55429

RE: Conditional License Number 405023
Health Facility Identification Number (HFID) 37939
Project Number(s) SL37939015

Dear Administrator:

The Minnesota Department of Health (MDH) completed an initial evaluation of your provisional assisted living license (PALF) on June 2, 2022, for the purpose of assessing compliance with state licensing statutes and to determine issuance of your initial assisted living facility license. At the time of the evaluation, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G. Based on the violations you were found not to be in substantial compliance.

Pursuant to Minn. Stat. § 144G.16, Subd. 3 (b), if a provisional licensee is not in substantial compliance with the initial survey, the commissioner shall either: (1) not issue the facility license and terminate the provisional license; or (2) extend the provisional license for a period not to exceed 90 calendar days and apply conditions necessary to bring the facility into substantial compliance. If the provisional licensee is not in substantial compliance with the survey within the period of the extension, or if the provisional licensee does not satisfy the license conditions, the commissioner may deny the license.

Based on the findings of the June 2, 2022, survey, your provisional assisted living facility license is extended for a period of 90 calendar days and conditions are imposed.

LICENSING ORDERS
The enclosed State Form documents the state licensing orders. The Department of Health documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Home Care 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 are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

IMPOSITION OF FINES

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

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

In accordance with Minn. Stat. § 144G.20, Subd. 4(a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572. Subds. 2, 9, 17. The Department of Health also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4(a)(5)(b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, no immediate fines are assessed.

DOCUMENTATION OF ACTION TO COMPLY

Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up evaluations. The licensee is not required to submit a plan of correction for approval.

The correction order documentation should include the following:

a. Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
b. Identify how the area(s) of noncompliance was corrected for all of the provider's residents/employees that may be affected by the noncompliance.
c. 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 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 Department of Health within 15 calendar days of the correction order receipt date.

A state licensing order under Minn. Stat. § 144G.91 Subd. 8), Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557. Please email general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

Please address your cover letter for general reconsideration requests to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

Free from Maltreatment reconsideration requests should addressed to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

LICENSE EXTENDED WITH CONDITIONS

Your provisional assisted living facility license #405023 expired on July 31, 2022. As noted above, the licensee was not in substantial compliance with the initial survey. Consequently, MDH is extending your provisional assisted living facility license for 90 calendar days from the date of this Notice and imposing conditions on the license necessary to bring the facility into compliance. **Your extended license with conditions will expire on November 30, 2022 (90 days from date of this letter).**

At an unannounced point in time during the conditional license period, MDH will conduct a follow-up evaluation, as defined in Minn. Stat. § 144G.30, Subd. 6. Based on the results of the follow-up evaluation, MDH will determine if Living Well Home Care is in substantial compliance.

The following conditions apply to the conditional provisional assisted living facility license:

i. **No new substantiated maltreatment allegations:** If any new investigations begin in the conditional license period, and the allegations are substantiated, MDH may deny the facility license and terminate the provisional license.

ii. **No new admissions:** Living Well Home Care will not admit any new residents under its conditional provisional assisted living facility license. Living Well Home Care must provide the Department:

1. A list of the names and birthdates of any individuals Living Well Home Care is currently in the process of admitting. These individuals will be able to continue the admission process.

2. A list of all current residents by location including:
    i. Name and birthdate of each resident
    ii. Physical location of each resident
    iii. Current payment source for services
    iv. If Elderly Waiver, the name and contact information of the care coordinator/case manager
    v. If the resident is not able to make informed decisions, the name of their representative and how to contact the representative

iii. Consultant: Living Well Home Care will contract with an RN to provide consultation concerning all resident(s) to whom Living Well Home Care provides licensed assisted living services under the conditional license. The consultant must have access to all resident(s) receiving services from Living Well Home Care. The consultant will conduct initial and ongoing evaluations of the provider. Direct resident observation may be required based on the consultant's judgement or at the discretion of MDH. The RN must not have any affiliation with Living Well Home Care, and MDH must review the RN's credentials and approve the selection. Living Well Home Care is responsible for the expense of the contract with the RN. The main purpose of the consultant is to provide guidance to Living Well Home Care in an effort to help Living Well Home Care align their practices with the requirements of Minn. Stat. §§ 144G.01 – 144G.9999 and to provide oral and written reports to MDH noting progress toward compliance and/or concerns about observations. Living Well Home Care will develop and implement policies, procedures, and processes specific to the offered services in accordance with the guidance provided by the consultant to ensure ongoing monitoring and compliance with statutory requirements.

iv. Reports: The RN consultant will provide MDH with regular reports at intervals specified by MDH. Reports will begin on a weekly basis until MDH notifies Living Well Home Care and the RN consultant about a change. Each report will be electronically submitted to Paul Spencer, Rapid Response Supervisor, **Office of Health Facility Complaints, Health Regulation Division at paul.spencer@state.mn.us. Paul can be reached at 651-587-4460 (office) with questions about reports. The content of the reports will include information including:**

i. Progress towards correction of licensing orders;
ii. Observations of staff delivering assisted living services and the level of competency observed;
iii. Conversations with residents and family members about satisfaction with assisted living services;

iv. Conversations with staff about their level of knowledge about the tasks they perform, the people they serve and the health professionals who delegate to them;
v. Overall impressions about the quality of the assisted living services delivered;
vi. Overall impressions about the dignity with which the residents and their family members are treated;
vii. Concerns; and
viii. Any other information requested by the Department or considered important by the RN consultant(s).

v. Monitoring visits: MDH may make unannounced monitoring visits to assess the progress of Living Well Home Care to correct the violations cited during the evaluation as well as to determine the overall practice of Living Well Home Care in meeting the needs of the people it serves. In addition, the Office of Ombudsman for Long-Term Care (OOLTC) may also make unannounced monitoring visits to determine the level of satisfaction of those people who receive licensed assisted living services. The OOLTC will share their findings with MDH.

vi. Follow-up Evaluation: At the time of the follow-up evaluation, MDH will determine if Living Well Home Care is in substantial compliance with the survey.

vii. Corrective Action Plan: Living Well Home Care will develop and work within a corrective action plan (CAP). The CAP is a working document that includes at least the following information:
i. A statement of the concern
ii. A description of what will happen to correct the concern
iii. A target date for when each correction will be complete
iv. Who is responsible to make sure it happens
v. Current status of correction work
vi. Description of a plan to monitor and ensure ongoing compliance for each corrected order

Results of Follow-Up Evaluation During the Conditional Provisional License Period:
MDH will determine if Living Well Home Care is in substantial compliance based on the results of the follow up evaluation. MDH will make this determination within the 90-day conditional provisional license period. If MDH determines Living Well Home Care is in substantial compliance on the follow up evaluation, MDH will remove the conditions from Living Well Home Care's provisional assisted living facility license and issue the assisted living facility license. Living Well Home Care will also be required to correct any violations identified during the follow up evaluation to come into full compliance. If MDH determines Living Well Home Care is not in substantial compliance, the assisted living facility license will be denied and the provisional license will be terminated.

RECONSIDERATION OF EXTENDED CONDITIONAL LICENSE WITH CONDITIONS

Pursuant to Minn. Stat. §144G.16, Subd. 4, a provisional licensee whose assisted living facility license has been extended with conditions may request a reconsideration by the commissioner. The request for reconsideration must be made in writing and must list and describe the reasons why the provisional licensee disagrees with the decision to extend the provisional license with conditions. The reconsideration request and supporting documentation must be received by the commissioner within 15 calendar days after the date of this notice. The request for reconsideration should be addressed to:

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

Please email requests for reconsideration to: Health.HRD.Appeals@state.mn.us.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this notice and the results of this visit with the President of your organization's Governing Body.

If you have any questions, please contact Paul Spencer directly at: paul.spencer@state.mn.us.

Sincerely,

Maria King

Maria King, RN
Division Director
Minnesota Department of Health
Health Regulation Division

PMB

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0 000	Initial Comments 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: SL#37939015 On June 1, 2022, through June 2, 2022, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey and investigation, there were three residents receiving services under the provider's Provisional Assisted Living Facility license. The following orders are issued as of July 20, 2022: 470. Additional correction orders may be issued at a later date. --- --- ---	0 000	Assisted Living Provider 144G. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	

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0 000	Continued From page 1 Please see additonal orders issued for this survey in this State Form with Orders (below).	0 000		
0 250 SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department;	0 250		

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	37939	A. BUILDING: _____ B. WING _____	06/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVING WELL HOME CARE	5019 61ST AVENUE NORTH BROOKLYN CENTER, MN 55429

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0 250	Continued From page 2 (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to show they met the requirements of licensure, by attesting the managerial officials who oversaw the day-to-day operations understood applicable statutes and rules; nor developed and/or implemented current policies and procedures as required with records reviewed. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	0 250		

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0 250	Continued From page 3 The findings include: During an interview on June 1, 2022, at 10:00 a.m., the licensed assisted living director (LALD)-A stated he was familiar with the assisted living regulations and the licensee provided medication and treatment management services. The licensee's Provisional Assisted Living Licensure Information and Application, section titled Official Verification of Owner or Authorized Agent, (page 16 and 17 of the application), identified, I certify I have read and understand the following: [a check mark was placed before each of the following]: - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G. - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659. - Reporting of Maltreatment of Vulnerable Adults. - Electronic Monitoring in Certain Facilities. - I understand pursuant to Minn. Stat. sect. 13.04 Rights of Subjects of Data, the commissioner will use information provided in this application, which may include an in-person or telephone conference, to determine if the applicant meets requirements for assisted living licensing. I understand I am not legally required to supply the requested information; however, failure to provide information or the submission of false or misleading information may delay the processing of my application or may be grounds for denying a license. I understand that information submitted to the commissioner in this application may, in some circumstances, be disclosed to the	0 250		

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0 250	Continued From page 4	0 250		

appropriate state, federal or local agency and law enforcement office to enhance investigative or enforcement efforts or further a public health protective process. Types of offices include Adult Protective Services, offices of the ombudsmen, health-licensing boards, Department of Human Services, county or city attorneys' offices, police, local or county public health offices.

- I understand in accordance with Inn. Stat. sect. 144.051 Data Relating to Licensed and Registered Persons (opens in a new window), all data submitted on this application shall be classified as public information upon issuance of a provisional license or license. All data submitted are considered private until MDH issues a license.

- I declare that, as the owner or authorized agent, I attest that I have read Inn. Stat. chapter 144G, and Minnesota Rules, chapter 4659 governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract.

- I have examined this application and all attachments and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct, and complete. I will notify MDH, in writing, of any changes to this information as required.

- I attest to have all required policies and procedures of Inn. Stat. chapter 144G and Inn.

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0 250	Continued From page 5 Rules chapter 4659 in place upon licensure and to keep them current as applicable. Page seventeen was signed by LALD-A on July 16, 2021. The licensee had a provisional assisted living license issued on August 1, 2021, with an expiration date of July 31, 2022. The licensee failed to ensure policies and procedures were developed and implemented to reference Minnesota Chapter 144G, Assisted Living. As a result of this survey, the following orders were issued 0470, 0480, 0490, 0550, 0570, 0580, 0640, 0650, 0660, 0680, 0730, 0780, 0800, 0810, 0950, 1370, 1380, 1470, 1480, 1540, 1610, 1620, 1640, 1690, 1750, 1880, 1910 indicating the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.08 to 144G.95. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 250		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (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	0 470		

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0 470	Continued From page 6 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 interview and document review, the licensee failed to ensure that one or more awake persons were available 24 hours per day, seven days per week, who were responsible for responding to the requests of residents for assistance with health or safety needs. This had the potential to affect all three residents. This practice resulted in a level two violation (a violation that did not harm a client'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).	0 470		

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0 470	Continued From page 7 The findings include: During an interview on June 1, 2022, at 10:00 a.m., the licensed assisted living director (LALD)-A stated the licensee had a "live in" staff member that worked from 7:00 a.m. on Saturday until 7:00 a.m. on Monday. The LALD stated the staff member slept when the residents did not require assistance. The licensee provided staffing schedule dated May 28-June 3, 2022, indicated unlicensed personnel (ULP)-D worked from 7:00 a.m. Saturday, May 28, 2022, until 7:00 a.m. Monday, May 30, 2022. TIME PERIOD FOR CORRECTION: Two (2) 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: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and	0 480		

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0 480	Continued From page 8 This MN Requirement is not met as evidenced by: Based on observation, and interview, 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 included document titled, Food and Beverage Establishment Inspection Report dated June 1, 2022, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 490 SS=F	144G.41 Subd 1 (13) (ii)-(vii) Minimum requirements (ii) weekly housekeeping; (iii) weekly laundry service; (iv) upon the request of the resident, provide direct or reasonable assistance with arranging for transportation to medical and social services appointments, shopping, and other recreation, and provide the name of or other identifying information about the persons responsible for providing this assistance; (v) upon the request of the resident, provide	0 490		

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0 490	Continued From page 9 reasonable assistance with accessing community resources and social services available in the community, and provide the name of or other identifying information about persons responsible for providing this assistance; (vi) provide culturally sensitive programs; and (vii) have a daily program of social and recreational activities that are based upon individual and group interests, physical, mental, and psychosocial needs, and that creates opportunities for active participation in the community at large; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to have daily programs of social and recreational activities based on individual and group interests, physical, mental, and psychosocial needs, which create opportunities for active participation in the community at large. This had the potential to affect all three residents. This practice resulted in a level two violation (a violation that did not harm a client'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: During an interview on June 1, 2022, at 10:00 a.m., the licensed assisted living director (LALD)-A stated the licensee provided a daily	0 490		

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0 490	Continued From page 10 program of social and recreational activities for the residents. During a facility tour on June 1, 2022, at 11:50 a.m., the surveyor did not observe a calendar for daily programs of social and recreational activities. During the survey on June 1 and June 2, 2022, the surveyor did not observe residents attending programs of social or recreational activities. During an interview on June 2, 2022, at 12:00 p.m., LALD-A stated the licensee did not currently provide daily programs of social and recreational activities. The licensee did not provide a policy to reference daily programs of social and recreational activities according to Minnesota Chapter 144G, Assisted Living. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 490		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the state and applicable regional 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	0 550		

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0 550	Continued From page 11 to the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on observation and interview, 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 all three residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a client'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: During a facility tour on June 1, 2022, at 11:50 a.m., the surveyor did not observe the licensee's posted grievance procedure. During the same tour, a posting was observed with contact information for the Office of Ombudsman for Long Term Care and the Ombudsman for Mental Health and Developmental Disabilities in the lower level of the home, which not all residents could access. During an interview on June 2, 2022, at 12:00 p.m., licensed assisted living director (LALD)-A verified the licensee did not have a posted grievance procedure. The licensee-provided Complaint/Grievance Posting Policy dated August 1, 2021, indicated the licensee would post in a conspicuous place	0 550		

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0 550	Continued From page 12 information about the complaint and grievance procedure, and the name, telephone number, and email contact information for the individual(s) who were responsible for handling resident complaints and grievances. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 550		
0 570 SS=C	144G.42 Subdivision 1 Display of license The original current license must be displayed at the main entrance of each assisted living facility. The facility must provide a copy of the license to any person who requests it. This MN Requirement is not met as evidenced by: Based on observation, and interview, the licensee failed to display the original current license at the main entrance of the assisted living facility. This had the potential to affect all three residents, staff, and 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 or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: During a facility tour on June 1, 2022, at approximately 11:50 a.m., the surveyor did not observe the licensee's original current license posted at the main entrance. During the same	0 570		

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0 570	Continued From page 13 tour, the original current license was posted on a bulletin board in the lower level of the home, which not all residents or visitors could access. During an interview on June 2, 2022, at 12:00 p.m., licensed assisted living director (LALD)-A, verified the original current license was not posted at the main entrance of the facility. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 570		
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to engage in and maintain documentation of quality management activity. This had the potential to affect all three residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	0 580		

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0 580	Continued From page 14 resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During an interview on June 1, 2022, at 10:00 a.m., licensed assisted living director (LALD)-A stated quality management activities ensuring policies and procedures were being followed, regular review of policies and procedures, and review of concerns were being conducted. During an interview on June 2, 2022, at 12:00 p.m., LALD-A stated the licensee did conduct quality management activities; however, the LALD was unable to present documentation during the survey. The licensee-provided Quality Improvement Project Policy dated September 20, 2018, did not reference Minnesota Chapter 144G, Assisted Living. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 580		
0 640	144G.42 Subd. 7 Posting information for reporting suspected c 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: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility;	0 640		

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0 640	Continued From page 15 (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 (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation, document review, and interview, the licensee failed to post in common areas and near telephones the 911 emergency number and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section?626.557. This had the potential to affect all three resident's, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a client'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: During a facility tour on June 1, 2022, at 11:50 a.m., the surveyor did not observe the 911 emergency number posted within the facility. During the same tour, the reporting number for the Minnesota Adult Abuse Reporting Center was posted on a bulletin board in the lower level of the home, which not all residents or visitors could access. During an interview on June 2, 2022, at 12:00	0 640		

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	37939	A. BUILDING: _____ B. WING _____	06/02/2022

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0 640	Continued From page 16 p.m., licensed assisted living director (LALD)-A verified the 911 emergency number and the reporting number for the Minnesota Adult Abuse Reporting Center were not posted in common areas of the facility. The licensee's provided Vulnerable Adult Maltreatment - Prevention & Reporting Policy dated August 1, 2021, indicated the licensee would post the 911 emergency number in common areas and near telephones provided by the assisted living facility and post information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 640		
0 650 SS=F	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs;	0 650		

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0 650	Continued From page 17 (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. (b) Each employee record must be retained for at least three years after a paid employee, volunteer, or contractor ceases to be employed by, provide services at, or be under contract with the facility. If a facility ceases operation, employee records must be maintained for three years after facility operations cease. This MN Requirement is not met as evidenced by: Based on observation, document review, and interview, the licensee failed to ensure employee records contained evidence of infection control training and required health screening for three of three employee files reviewed (licensed assisted living director (LALD)-A, unlicensed personnel (ULP)-B, and ULP-G). Additionally, one of three employee records reviewed (ULP-B) lacked a competency evaluation. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: LALD-A LALD-A was hired on July 10, 2020.	0 650		

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0 650	Continued From page 18 During an observation June 1 and June 2, 2022, the surveyor observed LALD-A assisting R1 and R2 with services as needed. LALD-A's employee record lacked documented evidence of infection control training and required health screenings. ULP-B ULP-B was hired on July 10, 2020. During observation on June 2, 2022, between 8:00 a.m. and 8:30 a.m., the surveyor observed ULP-B administering oral medications to R1, R2, and R3. ULP-B's employee record lacked documented evidence of infection control training, competency evaluations, and required health screenings. ULP-G ULP-G was hired on February 11, 2021. During observation on between 9:30 a.m. and 10:30 a.m., the surveyor observed ULP-D taking R1's vital signs, assisting R1 with bed mobility, transfers, hygiene, and toileting. ULP-G's employee record lacked documented evidence of infection control training, required health screenings, and a background check. During an interview on June 2, 2022, at 12:00 p.m., LALD-A stated the employee records provided to surveyor were what the licensee had for employee record content. The licensee did not have a policy to reference Minnesota Chapter 144G, Assisted Living.	0 650		

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0 650	Continued From page 19 TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (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. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to establish and maintain a comprehensive tuberculosis (TB) infection control prevention program according to the most current guidelines issued by the Centers for Disease Control (CDC), including a TB facility risk assessment, a baseline TB screening and testing for the presence of the infection with a two-step tuberculin skin test (TST) or single TB blood test, for seven of seven employees (Licensed assisted living director (LALD)-A, register nurse (RN)-C, and unlicensed personnel (ULP)-B, ULP-D, ULP-E, ULP-F, ULP-G) with records reviewed. This had the potential to affect all three residents	0 660		

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0 660	Continued From page 20 receiving assisted living services, as well as 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 the potential to affect a large portion or all the residents). The findings include: FACILITY TB RISK ASSESSMENT The CDC guidelines indicate a facility risk assessment should be performed on an annual basis to ensure infection control measures match the facilities risk level. The guidelines also indicated the level of infection control measures employed by the facility should match the risk classification for the setting. During an interview on June 1, 2022, at 10:25 a.m., licensed assisted living director (LALD)-A stated the licensee had a facility TB risk assessment. At the same time, the LALD was unable to indicate the licensee's facility risk level. The licensee's Facility TB Risk Assessment Worksheet for Health Care Settings Licensed by MDH, undated, was not completed. EMPLOYEE SCREENING AND EMPLOYEE TB TESTING RESULTS LALD-A LALD-A was hired on July 10, 2020.	0 660		

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0 660	Continued From page 21 LALD-A's employee record lacked a Baseline TB Screening Tool or evidence of TST. The record include a positive TB QuantiFERON Gold lab test dated July 24, 2020. During an interview on June 2, 2022, at 12:00 p.m., LALD-A stated he had repeated this lab draw. The LALD was unable to provide me the documentation. RN-C RN-C was hired on September 1, 2020. RN-C's employee record include a Baseline TB Screening Tool dated December 3, 2020. The record lacked evidence of a TST or blood test. ULP-B ULP-B was hired on July 10, 2020. ULP-B's employee record include a Baseline TB Screening Tool dated July 8, 2020, and a single chest x-ray dated March 7, 2019. The record lacked evidence of a TST or blood test. During an observation on June 2, 2022, between 8:00 a.m. and 8:30 a.m., the surveyor observed ULP-B administering medications to resident R1, R2, and R3. ULP-D ULP-D was hired on October 1, 2021. ULP-D's employee record lacked a Baseline TB Screening Tool, evidence of a TST, or a blood test. ULP-E ULP-E was hired on May 8, 2021.	0 660		

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0 660	Continued From page 22 ULP-E's employee record lacked a Baseline TB Screening Tool, evidence of a TST, or a blood test. ULP-F ULP-F was hired on, July 10, 2020. ULP-F's employee record lacked a Baseline TB Screening Tool, evidence of a TST, or blood test. The record did contain a single chest x-ray dated August 11, 2020. ULP-G ULP-G was hired on February 11, 2021. ULP-G's. ULP-G's employee record include a Baseline TB Screening Tool. The record lacked evidence of a TST or blood test. R1's medication administration record (MAR) indicated ULP-G administered oral medications to R1 on May 30, 2022. During an interview on June 2, 2022, at 12:00 p.m., LALD-A verified the Facility TB risk assessment was incomplete and verified each employee record was missing the TB information as noted above. LALD-A stated his understanding was employees only needed one TST. The licensee provided Tuberculosis & Staff Screening Policy dated October 31, 2018, indicated the licensee shall have an ongoing program for screening and educating staff on TB. The policy indicated the licensee shall complete a written community TB risk assessment and update the assessment data on an annual basis. The policy indicated new staff shall be screened using the Baseline TB Screening Tool and have a two-step Mantoux conducted with results	0 660		

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0 660	Continued From page 23 documented on the Baseline TB Screening Tool. The policy indicated no staff shall be permitted to begin working involving the sharing of air space with clients until the negative results of the first Mantoux are read and documented. The policy further indicated the TB screening results shall be kept in each employee's medical file. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
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 tenant 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	0 680		

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0 680	Continued From page 24 requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to develop a written emergency disaster plan with all the required content, provide initial and annual staff training, make annual training available to residents, post an emergency disaster plan prominently, provide building emergency exit diagrams to all residents, and post emergency exit diagrams on each floor. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: During a facility tour on June 1, 2022, at 11:50 a.m., the surveyor did not observe emergency exit diagrams posted on each floor, or an emergency preparedness plan in the common area of the facility. Review of the facility provided Disaster Planning and Emergency Preparedness Plan, dated October 31, 2018, indicated the licensee would have in place a written plan of action to facilitate the management of clients cares and services in response to a natural disaster or other emergencies that may disrupt their ability to provide care and/or services. The plan included a	0 680		

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0 680	Continued From page 25 three-page Hazard Vulnerability Analysis (HVA) procedure to determine the probability of events, the risk of events, and the level of current preparedness; the analysis was blank. The licensee's plan lacked the following required content: - a description of the facilities approach to meeting the health/safety/security needs of the staff and residents; - process for EP cooperation with state and local EP officials/organizations. - a thoroughly completed risk assessment; - arrangements/contracts to re-establish utility services; and - a description of the population served by the licensee. - development of policies/procedures to address: - procedure for tracking staff and residents; - subsistence needs for staff and residents during an emergency; - evacuation plan; - shelter in place; - a medical record documentation system to preserve resident information, security, and availability; - emergency staffing strategies to include volunteers; - development of arrangements with other facilities and providers to receive residents if needed; and - the facilities role in providing care and treatment at alternative sites. - a communication plan that included: - arrangement with other facilities; - names and contact information for staff, resident physicians, other facilities; - contact information for federal, state, tribal, local EP staff, ombudsman; - primary and alternative means for	0 680		

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0 680	Continued From page 26 communicating with facility staff, federal, state, regional and local emergency management agencies; - a method of sharing information and medical documentation for residents; and - a means to provide information regarding the facility's needs, and its ability to provide assistance to include information about their occupancy. - emergency preparedness training and documentation of training During an interview on June 2, 2022, at 12:00 p.m., LALD-A stated the licensee's Disaster Planning and Emergency Preparedness Plan was what the licensee used for their Emergency Preparedness plan. When asked what the licensee's plan would be if they needed to evacuate, LALD stated they would go to a neighboring home. When asked about how they would handle and eloped resident, LALD-A did not know what that meant. When explained, LALD-A stated the residents have a right to come and go as they wish. The licensee did not have a policy for missing resident. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of	0 730		

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0 730	Continued From page 27 the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or	0 730		

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0 730	Continued From page 28 status. This MN Requirement is not met as evidenced by: Based on document review and interview, the licensee failed to ensure the resident's record included the required content for one of one resident (R1) with records reviewed. 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 isolated scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During an interview on June 1, 2022, at 10:00 a.m., licensed assisted living director (LALD)-A stated the resident records were paper and everything the surveyor would need to review during the survey would be in the chart. Review of R1's medical record on June 1, 2022, at 1:30 p.m., indicated a signed Assisted Living Contract dated April 25, 2022, and paperwork from R1's previous place of residents. On June 1, 2022, 2:45 p.m., LALD-A provided the surveyor with the following documents for R1: -master care plan dated May 7, 2022. -initial assessment dated May 7, 2022, indicated it was completed remotely by registered nurse (RN)-C. -14-day assessment dated June 1, 2022, indicated it was completed in person by RN-C.	0 730		

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0 730	Continued From page 29 R1's medical record lacked evidence of the following items: -legal representative -service plans -records of communications pertinent to the resident's services -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; -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; -documentation that services have been provided as identified in the service plan; During an interview on June 2, 2022, at 1:30 p.m., LALD-A stated the licensee did not get much paperwork from the R1's previous facility and R1 was just assigned a new case manager, so the licensee was still working on all R1's paperwork. LALD-A verified the licensee did not have a completed face sheet for R1's medical file. The licensee did not have a policy which referenced Minnesota Chapter 144G, Assisted Living. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter	0 780		

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	37939	A. BUILDING: _____ B. WING _____	06/02/2022

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LIVING WELL HOME CARE	5019 61ST AVENUE NORTH BROOKLYN CENTER, MN 55429

(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
0 780	Continued From page 30 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (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 (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; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure smoke alarms are interconnected so that actuation of one alarm causes all alarms in the dwelling to actuate as required]. 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, but was not likely to cause serious injury, impairment, or death), and issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large	0 780		

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0 780	Continued From page 31 portion or all residents). The findings include: On June 02, 2022, between 8:50 a.m. and 9:30 a.m., survey staff toured the facility with the licensed assisted living director (LALD)-A. During the facility tour, survey staff requested the smoke alarms be tested. The alarms that were tested went off but did not cause all alarms to actuate. LALD-A verbally confirmed survey staff observations during the facility tour. No further information was provided.	0 780		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. 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	0 800		

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0 800	Continued From page 32 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 residents). The findings include: On June 2, 2022, from approximately 8:50 a.m. to 9:30 a.m., survey staff toured the facility with licensed assisted living director (LALD)-A. During the facility tour, survey staff observed the following: 1. There was a loose and warped board at the landing of the ramp at the building entrance. 2. The light in the basement laundry room did not stay on and was hanging from the ceiling by the wires. It was hanging low enough to bump the head of whoever was doing laundry. 3. The light in the basement bathroom would not stay in the on position. The switch was loose and would bounce back to the off position. LALD-A verbally confirmed survey staff observations during the facility tour. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The	0 810		

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0 810	Continued From page 33 plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide the required fire safety training and evacuation plans for residents and staff. This has the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a	0 810		

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0 810	Continued From page 34 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 the potential to affect a large portion or all residents). The findings include: On June 2, 2022, from approximately 8:50 a.m. to 9:30 a.m., survey staff toured the facility with licensed assisted living director (LALD)-A. During the facility tour, survey staff observed no evacuation plans posted. LALD-A verbally confirmed survey staff observations during the facility tour. During interview on June 2, 2022, at 9:45 a.m., LALD-A stated they had not done any drills or training yet. Review of the fire safety and evacuation plans showed their policies were outdated. Upon review the following items were not documented: 1. No evacuation plan or documentation on specific procedures for the residents including procedures for their movements, and relocation during a fire or similar, and no written instructions for addressing any unique situation during evacuation, especially for residents who are wheelchair-bound and need assistance during an evacuation. 2. No record of required employee evacuation drills.	0 810		

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0 810	Continued From page 35 3. No schedule or records on the training of employees on fire safety and evacuation; on proper actions to take in the event of a fire or emergency for the safety of residents including movement, evacuation, or relocation. 4. No schedule or records on the training of residents who are capable of assisting in their evacuation; on proper actions to take in the event of a fire or emergency for their safety including movement, evacuation, or relocation. 5. No fire safety and evacuation plan that showed the location and number of resident rooms. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 950 SS=D	144.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "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	0 950		

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0 950	Continued From page 36 Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to offer the opportunity to identify a designated representative for one of one resident (R1) with records reviewed. 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 isolated scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1's diagnoses included hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, alcohol dependence and abuse, major depressive disorder, and muscle spasms. R1's medical record lacked evidence of a signed	0 950		

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0 950	Continued From page 37 service plan. R1's Face sheet indicated a brother listed as an emergency contact. R1's Assisted Living Contract for Housing and Services dated April 20, 2022, signed by R1, included a section to name a designated representative. The section did not indicate a designated representative, and the box next to "resident declines to name a representative" was not initialed by R1. The licensee did not have a policy which referenced Minnesota Chapter 144G, Assisted Living. TIME PERIOD FOR CORRECTION: Twenty-one (21)	0 950		
01370 SS=F	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices;	01370		

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01370	Continued From page 38 (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on observation, document review, and interview the license failed to ensure training and competency evaluations contained all the required training prior to providing direct care for two of two unlicensed personnel (ULP-B and ULP-G) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a client'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	01370		

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01370	Continued From page 39 failure that has affected or has potential to affect a large portion or all of the residents). ULP-B ULP-B was hired on July 10, 2020. During an observation on June 2, 2022, between 8:00 a.m. and 8:30 a.m., the surveyor observed ULP-B administering oral medications to R1, R2, and R3. Review of ULP-B's employee record indicated ULP-B's record lacked evidence that the following education and competencies had been completed according to Minnesota Chapter 144G prior to ULP-B providing direct cares: - documentation requirements for all services provided; - reports of changes in the resident's condition to the supervisor designated by the facility; - basic infection control, including blood-borne pathogens; - appropriate and safe techniques in personal hygiene and grooming, including: - hair care and bathing; - care of teeth, gums, and oral prosthetic devices; - care and use of hearing aids; and - dressing and assisting with toileting; - training on the prevention of falls; - standby assistance techniques and how to perform them; - basic nutrition, meal preparation, food safety, and assistance with eating; - preparation of modified diets as ordered by a licensed health professional; - understanding appropriate boundaries between staff and residents and the resident's family; - maintenance of a clean and safe environment; - medication, exercise, and treatment reminders; - communication skills that include preserving the	01370		

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01370	Continued From page 40	01370		

dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family;
- awareness of confidentiality and privacy;
- understanding appropriate boundaries between staff and residents and the resident's family;
- procedures to utilize in handling various emergency situations; and
- awareness of commonly used health technology equipment and assistive devices

ULP-G
ULP-G was hired on February 11, 2021.

During an observation on June 2, 2022, between 9:30 a.m. and 10:30 a.m., the surveyor observed ULP-G taking R1's vital signs, assisting R1 with bed mobility, transfers, hygiene, and toileting.

Review of ULP-G's employee record indication ULP'G's record lacked evidence that the following education and competencies had been completed according to Minnesota Chapter 144G prior to ULP-G providing direct cares:
- documentation requirements for all services provided;
- reports of changes in the resident's condition to the supervisor designated by the facility;
- basic infection control, including blood-borne pathogens;
- appropriate and safe techniques in personal hygiene and grooming, including:
- hair care and bathing;
- care of teeth, gums, and oral prosthetic devices;
- care and use of hearing aids; and
- dressing and assisting with toileting;
- training on the prevention of falls;
- standby assistance techniques and how to perform them;
- basic nutrition, meal preparation, food safety,

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01370	Continued From page 41 and assistance with eating; - preparation of modified diets as ordered by a licensed health professional; - understanding appropriate boundaries between staff and residents and the resident's family; - maintenance of a clean and safe environment; - medication, exercise, and treatment reminders; - communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; - awareness of confidentiality and privacy; - understanding appropriate boundaries between staff and residents and the resident's family; - procedures to utilize in handling various emergency situations; and - awareness of commonly used health technology equipment and assistive devices ULP-G's employee record contained transcripts of courses completed but lacked evidence of completion of the above required training. During interview on June 2, 2022, at 12:00 p.m., LALD-A verified the required competencies were not in the employee file. The licensee provided Orientation Policy dated October 31, 2018, did not reference Minnesota Chapter 144G, Assisted Living. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01370		
01380 SS=F	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel	01380		

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01380	Continued From page 42 providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on observation, document review, and interview, the licensee failed to ensure training and competency evaluations contained all the required training prior to providing direct care for two of two unlicensed personnel (ULP-B, ULP-G) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-B ULP-B was hired on July 10, 2020.	01380		

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01380	Continued From page 43 During an observation on June 2, 2022, between 8:00 a.m. and 8:30 a.m., the surveyor observed ULP-B administering oral medications to R1, R2, and R3. Review of ULP-B's employee record indicated ULP-B's record lacked evidence of to indicate the employee had completed training as required in the following area according to Minnesota Chapter 144G prior to providing direct care services: - observation, reporting, and documenting of client status; - basic knowledge of body functioning and changes in body function, injuries, or other observed changes that must be reported to appropriate personnel; - reading and recording temperature, pulse, and respirations of the resident; - recognizing physical, emotional, cognitive, and developmental needs of the resident; - safe transfer techniques and ambulation; - range of motioning and positioning; and - administering medications or treatments as required ULP-G ULP-G was hired on February 11, 2021. During an observation on June 2, 2022, between 9:30 a.m. and 10:30 a.m., the surveyor observed ULP-G taking R1's vital signs, assisting R1 with bed mobility, transfers, hygiene, and toileting. During review of ULP-G's employee record ULP-G's record indicated it lacked evidence to indicate the employee had completed training as required in the following areas according to Minnesota Chapter 144G prior to providing direct care services:	01380		

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	37939	A. BUILDING: _____ B. WING _____	06/02/2022

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LIVING WELL HOME CARE	5019 61ST AVENUE NORTH BROOKLYN CENTER, MN 55429

(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
01380	Continued From page 44 - observation, reporting, and documenting of client status; - basic knowledge of body functioning and changes in body function, injuries, or other observed changes that must be reported to appropriate personnel; - reading and recording temperature, pulse, and respirations of the resident; - recognizing physical, emotional, cognitive, and developmental needs of the resident; - safe transfer techniques and ambulation; - range of motioning and positioning; and - administering medications or treatments as required ULP-G's employee record contained transcripts of courses completed but lacked evidence of completion of the above required training. During an interview on June 2, 2022, at 12:00 p.m., LALD-A verified the required competencies were not in the employee file. The licensee provided Orientation Policy dated October 31, 2018, did not reference Minnesota Chapter 144G, Assisted Living. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01380		
01470 SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff	01470		

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01470	Continued From page 45 person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated	01470		

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01470	Continued From page 46 age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to ensure three of three employees ((licensed assisted living director (LALD)-A, unlicensed personnel (ULP)-D, ULP-E)) received orientation to assisted living facility licensing requirements and regulations with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: LALD-A LALD-A was hired on July 10, 2020. During observations on June 1 and June 2, 2022, throughout the survey, LALD-A assisted R1 and R2 with services as needed. ULP-B ULP-B was hired on July 10, 2020.	01470		

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01470	Continued From page 47 During an observation on June 2, 2022, between 8:00 a.m. and 8:30 a.m., ULP-B administer R1, R2, and R3's oral medications. ULP-G ULP-G was hired on February 11, 2021. During an observation on June 2, 2022, between 9:30 a.m. and 10:30 a.m., ULP-D checked R1's vital signs, assisted R1 with bed mobility, transfers, hygiene, and toileting. LALD-A, ULP-B and ULP-G's records did not include documentation indicting the employees received orientation to include the following topics prior to providing assisted living services: - an overview of this chapter [144G] - an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person. - handling of emergencies and use of emergency services. - the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights. - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. - handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints. - consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or	01470		

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01470	Continued From page 48 other relevant advocacy services; and - a review of the types of assisted living services the employee will be providing and the facility's category of licensure During an interview on June 2, 2022, at 12:00 p.m., the LALD-A stated the employee records provided to surveyors was what the licensee had for employee record content. The licensee provided Orientation Policy dated October 31, 2018, did not reference Minnesota Statutes Chapter 144G Assisted Living. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
01480 SS=F	144G.63 Subd. 3 Orientation to resident Staff providing assisted living services must be oriented specifically to each individual resident and the services to be provided. This orientation may be provided in person, orally, in writing, or electronically. This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to ensure staff providing assisted living services were oriented specifically to each individual resident and the services to be provided for two of two employees (unlicensed personnel (ULP)-B, ULP-G) with records reviewed. 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	01480		

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01480	Continued From page 49 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 the potential to affect a large portion or all of the residents). The findings include: ULP-B ULP-B was hired on July 10, 2020. During an observation on June 2, 2022, between 8:00 a.m. and 8:30 a.m., ULP-B administer R1, R2, and R3's oral medications. ULP-B's employee record lacked evidence that ULP-B received resident specific orientation. ULP-G ULP-G was hired on February 11, 2021. During an observation on June 2, 2022, between 9:30 a.m. and 10:30 a.m., ULP-D checked R1's vital signs, assisted R1 with bed mobility, transfers, hygiene, and toileting. ULP-B's employee record lacked evidence that ULP-B received resident specific orientation. During an interview on June 2, 2022, at 12:00 a.m., licensed assisted living director (LALD)-A verified no documentation of resident specific orientation was in any employee records. The licensee did not have a policy which referenced Minnesota Chapter 144G, Assisted Living. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01480		

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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 by: Based on document review and interview, the licensee failed to ensure staff received the required amount of dementia care training in the required time frame for seven of seven employees (licensed assisted living director (LALD)-A, register nurse (RN)-C, and unlicensed personnel (ULP)-B, ULP-D, ULP-E, ULP-F, ULP-G) with records reviewed. 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	01540		

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01540	Continued From page 51 of the residents). The findings include: During an interview on June 1, 2022, at 10:00 a.m., the licensed assisted living director (LALD)-A stated none of the current residents had a diagnosis of dementia. LALD-A LALD-A was hired on July 10, 2020. LALD-A's employee record lacked evidence that LALD-A received the required dementia training. RN-C RN-C was hired on September 1, 2020. RN-C's employee record lacked evidence that RN-C received the required dementia training. ULP-B ULP-B was hired on July 10, 2020. ULP-B's employee record lacked evidence that ULP-B received the required dementia training. ULP-D ULP-D was hired on October 1, 2021. ULP-D's employee record lacked evidence that ULP-D received the required dementia training. ULP-E ULP-E was hired on May 8, 2021. ULP-E's employee record lacked evidence that ULP-E received the required dementia training. ULP-F ULP-F was hired on, July 10, 2020.	01540		

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01540	Continued From page 52 ULP-F's employee record lacked evidence that ULP-F received the required dementia training. ULP-G ULP-G was hired on February 11, 2021. ULP-G's. ULP-G's employee record lacked evidence that ULP-G received the required dementia training. During an interview on June 2, 2022, at 12:00 p.m., the LALD-A stated he did not believe the staff had to complete dementia training because the licensee did not accept residents with a diagnosis of dementia. The licensee Orientation Policy dated October 31, 2018, did not reference Minnesota Chapter 144G, Assisted Living. 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 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	01610		

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01610	Continued From page 53	01610		

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 document review and interview, the licensee failed to ensure a registered nurse (RN) completed a comprehensive assessment to include all areas identified on the uniform assessment tool for one of one resident (R1) with records reviewed.

This practice resulted in a level two violation (a violation that did not harm a residents 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:

Review of R1's medical record on June 1, 2022, at 2:45 p.m., indicated R1's diagnoses included hemiplegia and hemiparesis, alcohol dependence, major depressive disorder, and muscle spasms. The medical record indicated the following:
- Assisted Living Contract was signed on April 25, 2022.
- Admission assessment was completed on May 7, 2022.
- Master care plan dated May 7, 2022.
- Initial assessment dated May 7, 2022, indicated it was completed remotely by registered nurse

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01610	Continued From page 54 (RN)-C. - 14-day assessment dated June 1, 2022, indicated it was completed in person by registered nurse (RN)-C. R1's medical record lacked evidence of the following: - a nursing assessment by a RN of the physical and cognitive needs of R1 on the date of admission. - a service plan. During an interview on June 2, 2022, at 1:00 p.m., RN-C confirmed the licensee did not complete nursing assessments within the timeframe required. The licensee did not have a policy which referenced Minnesota Chapter 144G, Assisted Living. 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	01620		

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01620	Continued From page 55 completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on document review and interview, the licensee failed to ensure a registered nurse (RN) completed a comprehensive assessment to include all areas identified on the uniform assessment tool for one of one resident (R1) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a residents 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: Review of R1's medical record on June 1, 2022, at 2:45 p.m., indicated R1's diagnoses included hemiplegia and hemiparesis, alcohol dependence, major depressive disorder, and muscle spasms. The medical record indicated the following:	01620		

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01620	Continued From page 56 - Assisted Living Contract was signed on April 25, 2022. - Admission assessment was completed on May 7, 2022. - Master care plan dated May 7, 2022. - Initial assessment dated May 7, 2022, indicated it was completed remotely by registered nurse (RN)-C. - 14-day assessment dated June 1, 2022, indicated it was completed in person by registered nurse (RN)-C. During an interview on June 2, 2022, at 1:00 p.m., RN-C confirmed the licensee did not complete nursing assessments within the timeframe required. The licensee did not have a policy which referenced Minnesota Chapter 144G, Assisted Living. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services	01640		

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01640	Continued From page 57 and how to contact the Office of Ombudsman for Long-Term Care. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on document review and interview, the licensee failed to ensure a registered nurse (RN) completed a comprehensive assessment to include all areas identified on the uniform assessment tool for one of one resident (R1) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a residents 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: Review of R1's medical record on June 1, 2022, at 2:45 p.m., indicated R1's diagnoses included hemiplegia and hemiparesis, alcohol dependence, major depressive disorder, and muscle spasms. The medical record indicated the following: - Assisted Living Contract was signed on April 25,	01640		

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	37939	A. BUILDING: _____ B. WING _____	06/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVING WELL HOME CARE	5019 61ST AVENUE NORTH BROOKLYN CENTER, MN 55429

(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
01640	Continued From page 58 2022. - Admission assessment was completed on May 7, 2022. - Master care plan dated May 7, 2022. - Initial assessment dated May 7, 2022, indicated it was completed remotely by registered nurse (RN)-C. - 14-day assessment dated June 1, 2022, indicated it was completed in person by registered nurse (RN)-C. R1's medical record lacked evidence of the following: - a nursing assessment by a RN of the physical and cognitive needs of R1 on the date of admission. - a service plan. During an interview on June 2, 2022, at 1:00 p.m., RN-C confirmed the licensee did not complete nursing assessments within the timeframe required. The licensee did not have a policy which referenced Minnesota Chapter 144G, Assisted Living. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01690 SS=F	144G.71 Subdivision 1 Medication management services (a) This section applies only to assisted living facilities that provide medication management services. (b) An assisted living facility that provides medication management services must develop, implement, and maintain current written	01690		

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01690	Continued From page 59	01690		

medication management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse, licensed health professional, or pharmacist consistent with current practice standards and guidelines.
(c) The written policies and procedures must address requesting and receiving prescriptions for medications; preparing and giving medications; verifying that prescription drugs are administered as prescribed; documenting medication management activities; controlling and storing medications; monitoring and evaluating medication use; resolving medication errors; communicating with the prescriber, pharmacist, and resident and legal and designated representatives; disposing of unused medications; and educating residents and legal and designated representatives about medications. When controlled substances are being managed, the policies and procedures must also identify how the provider will ensure security and accountability for the overall management, control, and disposition of those substances in compliance with state and federal regulations and with subdivision 23.

This MN Requirement is not met as evidenced by:
Based on observation, document review, and interview, the licensee failed to ensure controlled substances were being managed and accounted for according to their policy and procedure. This had the potential to affect all three of the licensee's residents.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a

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01690	Continued From page 60	01690		

widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).

The findings include:

During an interview on June 1, 2022, at 10:00 a.m., licensed assisted living director (LALD)-A confirmed the licensee provided medication management services to the licensee's residents.

During an observation on June 2, 2022, at 10:40 a.m., the surveyor observed the following items in the licensee's narcotic lock box:

- Bubble pack with label for R2: Clonazepam tab 1 mg, take 1 tablet by mouth at bedtime as needed for anxiety "4 total fills". Disp: 05/05/2022. Exp: 05/04/2022. Next Available Refill: 05/29/2022. The bubble pack contained one green pill in bubble number 30 and one green pill in bubble number 31.

- Belsomra (suvorexant) tablets 5 mg empty container. The container had no label indicating which resident it was used for, indications for use, dates, or directions.

- Pill bottle with label of a discharged resident: Oxycodone-Acetaminophen. Nine white pills remained in the bottle.

During the same observation, R2's medication tender was observed to have a green pill in the Saturday morning, noon, and bedtime slots. R2's medication tender was locked in the medication cabinet but was not double locked in the narcotic lock box.

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01690	Continued From page 61 Review of the Narcotic logbook on June 2, 2022, at 10:40 a.m. indicated the following on page: - 1 of 116 in the upper section - the name of a discharged resident, the medication name (Oxycodone-Acetaminophen), the prescription number (Rx#), no prescribing physician, initial quantity received (10), no date received, and no pharmacy. No dosage/directions were indicated. On line one the date was entered as 6/2021, time was blank, on hand quantity indicated 12, given quantity indicated 1, remaining quantity indicated 9, signed by RN-B. The rest of the page was blank. - 2 of 116 in the upper section - R2's name, the medication name (Clonazepam 1 mg), the Rx#, the prescribing physician, initial quantity received (30 tabs bottle #6), date received (6/2/21), and no pharmacy. Dosage/directions indicated take 1 mg by mouth at bedtime. On line one the date was entered as 7/1, the time was 1313, on hand quantity was 30, given quantity indicated prepped 16, remaining quantity indicated 3, signed by RN-B. The rest of the page was blank. - 3 of 116 in the upper section - R2's name, the medication name (Belsomra). The rest of the page was blank. - 4 of 116 in the upper section - R2's name, the medication name (Clonazepam 1 mg), the Rx#, no prescribing physician, initial quantity received (30 in bubble pack), date received (11/3/21), and pharmacy. No dosage/directions were indicated. On line one the date was entered as 11/4, no time was indicated, on hand quantity indicated 30, given quantity indicated prepped 1, remaining quantity indicated 29, signed by RN-B. The rest of the page was blank.	01690		

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01690	Continued From page 62 During an interview on June 2, 2022, at 1:07 p.m., the RN-B stated she is at the facility one to two times per week and works approximately 16 hours bi-weekly. The RN-B stated she tries to count the narcotics every time she is at the facility. The RN-B stated she stopped documenting the count checks in the narcotic logbook and started documenting them in the electronic medical approximately July 2021. The RN stated she was unaware the licensee had a Narcotic Log Policy. Review of the licensee Narcotic Log Policy dated October 31, 2018, indicated all controlled substances must be recorded on an individual page in the bound narcotic logbook. The policy indicated controlled substances would be counted and recorded on the narcotic count sheet and compared with the quantities listed in the narcotic logbook at the start of the day shift and during the evening shift. The policy indicated this count would only be recorded in the narcotic count sheet and not on the medication administration record (MAR). The policy further indicated the RN supervisor would verify the documentation in the narcotic logbook including counts and records regularly. The licensee did not have a policy referencing Minnesota Chapter 144G, Assisted Living. TIME PERIOD FOR CORRECTION: Seven (7) days	01690		
01750 SS=F	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated	01750		

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01750	Continued From page 63 to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, document review, and interview, the licensee failed to ensure one of one unlicensed personnel (ULP)-B demonstrated competency for administering medications. This had the potential to harm all three residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings included: ULP-B started employment on July 10, 2020. During an observation on June 2, 2022, between 8:00 a.m. and 8:30 a.m., the surveyor observed ULP-B administering R1, R2, and R3's oral medications. ULP-B's record lacked evidence of medication administration competency evaluation.	01750		

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01750	Continued From page 64 During an interview on June 8, 2022, at 3:30 p.m., ULP-B stated the previous registered nurse (RN) provided medication training during orientation, including competency training. ULP-B stated the current RN also completed a medication evaluation in January or February of 2022. The licensee did not have a current medication delegation policy which referenced Minnesota Chapter 144G, Assisted Living. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to store all prescription medications in a securely locked compartment. 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).	01880		

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01880	Continued From page 65 The findings include: During a tour on June 1, 2022, at 11:50 p.m., the surveyor observed the medication storage unit, a four-drawer file cabinet located in the lower level of the home, with the key hanging from the lock and no staff was present. During an observation on June 2, 2022, at 10:40 a.m., the surveyor observed unlicensed personnel (ULP)-G remove the medication file cabinet key from the left side of the file cabinet and unlock the cabinet. ULP-G stated that is where they hang keep the key. The licensee provided Storage of Medications Policy dated October 31, 2018, indicated medications managed by the home care provider shall be stored to prevent diversion of medications by clients or others who may have access to the medications. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01910 SS=F	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service	01910		

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01910	Continued From page 66 contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on observation, document review, and interview, the licensee failed to dispose of expired medication for one of three residents (R3) and dispose of medication upon termination of the service contract for one of one discharged resident(R4). This had the potential to This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R3 During an observation on June 2, 2022, at 8:20 a.m., the surveyor observed R3's Multivitamin with Iron oral tablets with an expiration date of March 2022 in the medication storage cart. R3's Physician Orders dated June 14, 2022, listed Certavite one tablet by mouth one time per day.	01910		

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01910	Continued From page 67 R3's medication administration record (MAR) dated June 2022, indicated R3 received Multivitamin with Iron and unlicensed personnel administered one tablet oral every day. During an interview on June 2, 2022, at 8:30 a.m., unlicensed personnel (ULP)-B acknowledged the presence of the expired medication in the medication cart and removed the medication immediately. R4 During an observation of narcotic storage on June 2, 2022, at 10:40 a.m. with ULP-G, the surveyor observed a bubble pack medication card with R4's name on it. The card was contained nine pills and was labeled oxycodone-acetaminophen. ULP-G stated R4 had been gone from the facility for a long time. During an interview on June 2, 2022, at 1:10 p.m., registered nurse (RN)-C stated she was not aware of the expired medications for R3. RN-C stated R4 discharge around July 1, 2021, and RN-C just has not taken the time to dispose of R4's unused medication following R4's discharge. The licensee provided Storage of Medications Policy dated October 31, 2018, indicated schedule II drugs would be counted at the beginning and end of every shift, as an optional but suggested way to protect staff and minimize diversion. The licensee provided Narcotic Log Policy dated October 31, 2018, indicated discontinued controlled substances will continue to be counted until they can be destroyed.	01910		

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01910	Continued From page 68 The licensee lacked policies referencing Minnesota Chapter 144G, Assisted Living. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		

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

Type: Full
Date: *06/01/22*
Time: 09:00:22
Report: 1018221078

Food and Beverage Establishment Inspection Report

Location:
Living Well Home Care
5019 61st Avenue North
Brooklyn Center, MN55429
Hennepin County, 27

Establishment Info:
ID #: 0040100
Risk:
Announced Inspection: No

License Categories:

Expires on: 12/31/22

Operator:

Phone #:
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.

2-200 Employee Health

2-201.11C ** Priority 1 **

MN Rule 4626.0040C The person in charge must record all reports of diarrhea or vomiting made by food employees and report those illnesses to the regulatory authority at the specific request of the regulatory authority.

FIRM DOES NOT CURRENTLY HAVE A PLACE TO RECORD INSTANCES OF VOMITING AND DIARRHEA IN FOOD WORKERS. COMPLY WITH RULE.

Comply By: 06/01/22

3-500C Microbial Control: date marking

3-501.17B ** Priority 2 **

MN Rule 4626.0400B Mark the refrigerated, ready-to-eat, TCS food prepared and packaged in a processing plant and opened and held for more than 24 hours in the food establishment using an effective method to indicate the date by which the food must be consumed on the premises, sold, or discarded. The date must not exceed the manufacturer's use-by-date.

OPENED CONTAINERS OF DELI MEAT AND CREAM CHEESE WERE OBSERVED WITHOUT DATE MARKS. COMPLY WITH RULE.

Comply By: 06/01/22

4-100 Equipment Construction Materials

4-101.19

MN Rule 4626.0495 Remove non-food-contact surfaces of equipment that are exposed to splash, spillage, or other food soiling, or that require frequent cleaning, that are not constructed of a corrosion-resistant, non-absorbent, and smooth material.

STOVE IS PROPPED UP ON WOODEN BLOCKS IN THE KITCHEN. DISCUSSED WITH THE

Type: Full
Date: *06/01/22*
Time: 09:00:22
Report: 1018221078
Living Well Home Care

Food and Beverage Establishment Inspection Report

MANAGER THAT WOOD IS NOT AN APPROVED MATERIAL FOR KITCHEN. COMPLY WITH RULE.

Comply By: 06/02/22

Food and Equipment Temperatures

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

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

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

KITCHEN IS INSIDE OF A RESIDENTIAL HOME. PHYSICAL FACILITIES WERE OBSERVED TO BE IN GOOD REPAIR.

DISHWASHER WAS OBSERVED TO HAVE SANITIZE FUNCTION AVAILABLE.

ALL FOOD PREPARED IN THE FIRM IS FOR SAME DAY SERVICE.

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

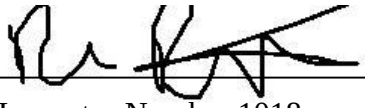
I acknowledge receipt of the Minnesota Department of Health inspection report number 1018221078 of 06/01/22.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/ /_____

Inspection report reviewed with person in charge and emailed.

Signed:_____
SAYLEE SUWORGO
MANAGER

Signed: 
Inspector Number 1018

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