



Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF REMOVAL OF CONDITIONAL LICENSE

Electronic Delivery

December 10, 2024

Licensee
Twin Cities Nursing Care
1635 Hazel Street North
Saint Paul, MN 55119

RE: License Number 414873
Health Facility Identification Number (HFID) 31262
Project Number(s) SL31262015

Dear Licensee:

On November 26, 2024, The Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed August 7, 2024. The follow-up survey found the facility to be in substantial compliance. **Based on these findings, the condition(s) on the license were removed effective December 9, 2024.**

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

Furthermore, the follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the 08072024 initial survey.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a), state correction orders issued pursuant to the last survey completed on August 7, 2024, found not corrected at the time of the follow-up survey follow-up survey and/or subject to a penalty assessment are as follows:

0680-Disaster Planning And Emergency Preparedness-144g.42 Subd. 10 - \$500.00

The details of the violations noted at the time of this follow-up survey completed on November 26, 2024 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Also, at the time of this follow-up survey completed on November 26, 2024, we identified the following violation(s):

1760-Documentation Of Administration Of Medication-144g.71 Subd. 8

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

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

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

IMPOSITION OF FINES:

Level 1: no fines or enforcement.

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

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

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

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

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has

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

To submit a hearing request, please visit:

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

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

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

Sincerely,

A handwritten signature in black ink that reads "Rick Michals". The signature is written in a cursive, flowing style.

Rick Michals, J.D.
Executive Regional Operations Manager

Minnesota Department of Health
Health Regulation Division

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31262	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 11/26/2024
NAME OF PROVIDER OR SUPPLIER TWIN CITIES NURSING CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 1635 HAZEL STREET NORTH SAINT PAUL, MN 55119			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
{0 000}	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL31262015-1 On November 25, 2024, through November 27, 2024, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on August 7, 2024. At the time of the survey, there were three residents; three receiving services under the Assisted Living license. As a result of the follow-up survey, the following orders were reissued.	{0 000}	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
{0 480} SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	{0 480}			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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{0 480}	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by:	{0 480}	Not reviewed during this survey.		
{0 680} SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule.	{0 680}			

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{0 680}	Continued From page 2 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to have a written emergency preparedness (EP) plan with all the required content and practice and document testing of its EP plan at least twice annually as required. This had the potential to affect all residents, staff, and visitors of the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: EMERGENCY PREPAREDNESS PLAN CONTENT The licensee's EP plan consisted of a risk assessment, communication plan, various policies/procedures and documents dated October 15, 2024. The licensee lacked a customized EP plan to include the following required content: - Policy/procedure for tracking staff; - Policy/procedure for sheltering in place; On November 26, 2024, at 10:45 a.m., owner/clinical nurse supervisor/licensed assisted living director (O/CNS/LALD)-A stated the licensee's EP plan lacked the above required components. O/CNS/LALD-A indicated the development of these policies had been missed.	{0 680}			

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{0 680}	Continued From page 3 TESTING OF EP PLAN The EP plan lacked evidence the facility had tested it's EP plan, conducted and/or participated in a full-scale community-based exercise, or conducted a tabletop exercise to test it's plan and document the results of testing at least twice annually as required. On November 26, 2024, at 10:45 a.m., O/CNS/LALD-A stated the licensee's EP plan lacked the above required components. O/CNS/LALD-A stated she had not conducted or participated in any tabletop or full-scale community-based exercises but was planning on doing a tabletop with staff soon in the near future. The licensee's Emergency and Disaster Preparedness policy dated October 15, 2024, included: 6. Our facility has developed and implements emergency preparedness policies and procedures in compliance with 42 C.F.R 483.73(c). 11. Training and Exercises (c) The facility conducts exercises to test the Emergency Preparedness Plan at least twice per year in compliance with 42 C.F.R 483.73(d)(2). Per Assisted Living Facilities: Minnesota Rules Chapter 4695, 4659.0100, sections A and B, assisted living facilities shall comply with the federal emergency preparedness regulations for long-term care facilities under Code of Federal Regulations, title 42, section 483.73, or successor requirements. This part references documents, specifications, methods, and standards in "State Operations Manual Appendix Z - Emergency Preparedness for All Providers and Certified Supplier Types: Interpretive Guidance," which is	{0 680}			

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{0 680}	Continued From page 4 incorporated by reference. No further information was provided.	{0 680}			
{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:	{0 780}			
{0 790} SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment	{0 790}	Not reviewed during this survey.		

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{0 790}	Continued From page 5 (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by:	{0 790}	Not reviewed during this survey.		
{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:	{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	{0 810}	Not reviewed during this survey.		

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{0 810}	Continued From page 6 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 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:	{0 810}			
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication	01760	Not reviewed during this survey.		

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01760	Continued From page 7 Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure each medication administered was documented with the complete required content or the reason why medication administration was not completed for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on November 25, 2024, at 11:25 a.m., owner/clinical nurse supervisor/licensed assisted living director	01760			

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01760	Continued From page 8 (O/CNS/LALD)-A stated the licensee provided medication management services to the licensee's residents. R2's diagnoses included diabetes mellitus type II, major depression, and hypertension. R2's Service Plan dated November 6, 2024, indicated R2 received assistance with bathing, hygiene/grooming, dressing, laundry, housekeeping, food preparation, and medication administration. R2's prescriber orders dated November 14, 2024, included: - Novolog FlexPen (rapid-acting insulin) 8 units subcutaneously three times daily before meals. HOLD if blood sugar level less than 150. R2's medication administration record (MAR) dated November 1, 2024, through November 26, 2024, included Novolog FlexPen inject 8 units subcutaneously three times daily before meals, Hold if blood sugar level less than 150, and initials to indicate the medication had been administered on some dates. In addition, the MAR included circled initials on the following dates and times to indicate the medication had not been administered or held. However, there was no documentation for the reason why the medication administration was not completed: -November 4, 2024, noon dose and no blood sugar recorded; -November 5, 2024, noon dose and no blood sugar recorded; -November 6, 2024, noon dose and no blood sugar recorded; -November 7, 2024, noon dose and no blood sugar recorded; -November 8, 2024, noon dose and no blood	01760			

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01760	Continued From page 9 sugar recorded; -November 11, 2024, noon dose and no blood sugar recorded; -November 12, 2024, noon dose and no blood sugar recorded; -November 13, 2024, noon dose and no blood sugar recorded; -November 14, 2024, evening dose and no blood sugar recorded; -November 15, 2024, evening dose and no blood sugar recorded; -November 18, 2024, noon dose and no blood sugar recorded; -November 19, 2024, noon dose and no blood sugar recorded; -November 20, 2024, noon dose and no blood sugar recorded; -November 22, 2024, evening dose and no blood sugar recorded; and -November 25, 2024, noon dose and no blood sugar recorded; On November 26, 2024, at 9:00 a.m., unlicensed personnel (ULP)-B stated she circles her initials on the MAR when R2's insulin is not administered but does not document the reason why the medication was not given. ULP-B indicated she had not been trained to do so. On November 26, 2024, at 9:04 a.m., owner/clinical nurse supervisor/licensed assisted living director (O/CNS/LALD)-A stated R2 goes to daycare 4-5 times a week and they do not send his insulin with. O/CNS/LALD-A stated there was no documentation for the above noted dates as to why the medication was not administered as ordered. O/CNS/LALD-A further stated staff need to document why a medication was not given and she would be clarifying the order with R2's prescriber.	01760			

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01760	Continued From page 10 The licensee's Documentation of Medication, Treatment and Therapy Management Services policy dated October 5, 2024, included: 2. Documentation will follow professional standards for documentation, including the requirement that entries must be: f. If refuse or not given, initial and circle for refusals or not given and document why. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760			



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NOTICE OF CONDITIONAL LICENSE

Electronically Delivered

September 4, 2024

Licensee
Twin Cities Nursing Care
1635 Hazel Street North
Saint Paul, MN 55119

RE: Conditional License Number 414873
Health Facility Identification Number (HFID) 31262
Project Number(s) SL31262015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 7, 2024, for the purpose of assessing compliance with state licensing statutes. Based on the survey results you were found not to be in substantial compliance with the laws pursuant to Minnesota Statutes, Chapter 144G.

As a result, pursuant to Minn. Stat. § 144G.20, MDH is issuing a 90-day conditional license due to expire on **December 3, 2024**.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement.

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

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

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

§ 144G.20.

In accordance with Minn. Stat. § 144G.31, Subd. 4(a)(5), MDH may impose fine amounts of either \$1,000 or \$5,000 to licensees who are found to be responsible for maltreatment. MDH may impose 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. MDH 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(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.

MDH may assess fines based on the level and scope of the orders outlined below. The total amount of **potential** fines that may be assessed related to these correction orders is \$6,000.00. **MDH is not imposing these fines against your license at this time.**

St - 0 - 0820 - 144g.45 Subd. 2 (g) - Fire Protection And Physical Environment - \$3,000.00

St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - \$3,000.00

DOCUMENTATION OF ACTION TO COMPLY

In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders and immediately correct any reissued orders outlined on the state form; however, plans of correction are not required to be submitted for approval. **If corrections are not made, MDH may impose fines as described above and in accordance with Minnesota Statutes 144G.**

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

A state correction 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.

To submit a reconsideration request, please visit:

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

CONDITIONAL LICENSE ISSUED:

MDH will issue Twin Cities Nursing Care a conditional assisted living facility license for 90 calendar days from the date of this notice. At an unannounced point in time, within the 90 calendar days, MDH will conduct a follow-up survey, as defined in Minn. Stat. § 144G.30, Subd. 6. Based on the results of the follow-up survey, MDH will determine if Twin Cities Nursing Care is in substantial compliance.

The following conditions apply on the conditional assisted living facility license:

- a. No new substantiated maltreatment allegations:** If any new investigations begin in the conditional license period, and the allegations are substantiated, MDH may pursue additional enforcement actions up to and including immediate temporary suspension and revocation of the license.
- b. No new admissions:** Twin Cities Nursing Care will not admit any new residents under its conditional assisted living facility license until MDH removes the “no new admissions” condition. Twin Cities Nursing Care must provide the Department:
 - i. A list of the names and birthdates of any individuals Twin Cities Nursing Care is currently in the process of admitting. These individuals will be able to continue the admittance process.
 - ii. A list of all current residents by location including:
 - 1. Name and birthdate of each resident
 - 2. Physical location of each resident
 - 3. Current payment source for services
 - 4. If Elderly Waiver, the name and contact information of the care coordinator/case manager
 - 5. If the resident is not able to make informed decisions, the name of their representative and how to contact the representative
- c. Consultant:** Twin Cities Nursing Care will contract with an RN to provide consultation concerning all resident(s) to whom Twin Cities Nursing Care provides licensed assisted living services under the conditional license. The consultant must have access to all resident(s) receiving services from Twin Cities Nursing 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 Twin Cities Nursing Care and MDH must review the RN's credentials and approve the selection. Twin Cities Nursing Care is responsible for the expense of the contract with the RN. The main purpose of the consultant is to provide guidance to Twin Cities Nursing Care in an effort to help Twin Cities Nursing 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 substantial compliance and/or concerns about observations. Twin Cities Nursing 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 substantial compliance with statutory requirements.

- d. 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 Twin Cities Nursing Care and the RN consultant about a change. Each report will be electronically submitted to Jodi Johnson, Surveyor Supervisor, State Evaluation Team, Health Regulation Division, at Jodi.Johnson@state.mn.us. Jodi Johnson can be reached at 507-344-2730 (office) with questions about reports. The content of the reports will include information such as:
- i. Progress towards correction of 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).
- e. Health Facility Construction Permit:** Twin Cities Nursing Care, will replace at Minnesota Department of Labor and Industry (MNDLI) or City with delegated authority to review and inspect State Licensed Facilities in accordance with Minn. Stat. § 326B.103, Subd. 13 and obtain a construction permit for a health facility. Within 21-days from the date of this notice, Twin Cities Nursing Care will provide MDH with a copy of the obtained from MNDLI or City with delegated authority.

- f. General Contractor:** Twin Cities Nursing Care must provide the follow to Tim Hanna, Supervisor, at Tim.Hanna@state.mn.us, within 21-days of the date of this notice:

 - I. Name
 - II. License Number (if required)
 - III. Contact Information

- c. Egress Window Requirements:** Twin Cities Nursing Care will replace at least one window in resident bedroom #1, meeting the minimum size requirements:

 - i. Must have a minimum openable width of no less than 20 inches
 - ii. Must have a minimum openable height of no less than 20 inches
 - iii. Must have a total openable area of no less than 648 square inches (4.5 square fee).
 - iv. Must have a windowsill height of no more than 48 inches from the floor to the clear opening.

- g. Monitoring visits:** MDH may make unannounced monitoring visits to assess the progress of Twin Cities Nursing Care to correct the violations cited during the survey as well as to determine the overall practice of Twin Cities Nursing 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.

- h. Follow-up survey:** At the time of the follow-up survey, MDH may pursue additional enforcement actions, up to and including immediate temporary suspension or revocation of the license if MDH identifies any level 3 or 4 violations or widespread care related violations.

- i. Corrective Action Plan:** Twin Cities Nursing 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 substantial compliance for each corrected order

RESULTS OF FOLLOW-UP EVALUATION DURING THE CONDITIONAL LICENSE PERIOD:

MDH will determine if Twin Cities Nursing Care is in substantial compliance based on the results of the

follow up survey. MDH will make this determination within the 90-day conditional license period. If MDH determines Twin Cities Nursing Care is in substantial compliance on the follow up survey, MDH will remove the conditions from Twin Cities Nursing Care's assisted living facility license, and Twin Cities Nursing Care will correct any outstanding violations identified during the survey. If Twin Cities Nursing Care is not in substantial compliance on the follow-up survey, MDH may take additional enforcement action, up to and including immediate temporary suspension and revocation, as authorized by Minn. Stat. § 144G.20.

REQUESTING A HEARING:

Pursuant to Minn. Stat. §144G.20, Subd. 18, the licensee may appeal an action against the license under this section. The licensee must request a hearing no later than 15 business days after licensee receives notice of the action. To submit a hearing request, please visit <https://forms.web.health.state.mn.us/form/HRD-Appeals-Form>.

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

If you have any questions, please contact Jodi Johnson directly at: 507-344-2730.

Sincerely,

A handwritten signature in black ink that reads "Rick Michals". The signature is written in a cursive, flowing style.

Rick Michals, J.D.

Executive Regional Operations Manager

**Minnesota Department of Health
Health Regulation Division**

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31262	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/07/2024
NAME OF PROVIDER OR SUPPLIER TWIN CITIES NURSING CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 1635 HAZEL STREET NORTH SAINT PAUL, MN 55119			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL31262015-0 On August 5, 2024, through August 7, 2024, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were three residents; three receiving services under the provider's Assisted Living Facility license. An immediate correction order was identified on Agust 6, 2024, issued for SL31262015-0, tag identification 0820. On August 7, 2024, the immediacy of correction order 0820 was removed, however non-compliance remained at an scope and level of H.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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0 250	Continued From page 1	0 250			
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, or interferes with or impedes access by the Office of Ombudsman for Mental Health and Developmental Disabilities according to section 245.94, subdivision 1; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department;	0 250			

Minnesota Department of Health

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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 record review, the licensee failed to show they met the requirements of licensure, by attesting the managerial officials who oversaw the day-to-day operations understood applicable statutes and rules; nor developed and/or implemented current policies and procedures as required with records reviewed. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	0 250			

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0 250	Continued From page 3 The findings include: During the entrance conference on August 5, 2024, at 12:04 p.m., owner/clinical nurse supervisor/licensed assisted living director (O/CNS/LALD)-A stated the licensee's employees in charge of the facility were familiar with the assisted living regulations and the licensee provided medication and treatment management services. The licensee's Application for Assisted Living License, section titled Official Verification of Owner or Authorized Agent, (page five and six of the application), identified, I certify I have read and understand the following: [a check mark was placed before each of the following]: - I have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section] 144G.45, my building(s) must comply with subdivisions 1-3 of the section, as applicable section Laws 2020, 7th Spec. [special] Sess [session]., chpt. [chapter] 1. art. [article] 6, sect. 17. - I have read and fully understand Minn. Stat. sect. 144G.80, 144G.81. and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22, my building(s) must comply with these sections if applicable. - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G. - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659. - Reporting of Maltreatment of Vulnerable Adults.	0 250			

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0 250	Continued From page 4 - 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 appropriate state, federal or local agency and law enforcement office to enhance investigative or enforcement efforts or further a public health protective process. Types of offices include Adult Protective Services, offices of the ombudsmen, health-licensing boards, Department of Human Services, county or city attorneys' offices, police, local or county public health offices. - I understand in accordance with Minn. Stat. sect. 144.051 Data Relating to Licensed and Registered Persons (opens in a new window), all data submitted on this application shall be classified as public information upon issuance of a provisional license or license. All data submitted are considered private until MDH issues a license. - I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659 governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and	0 250			

Minnesota Department of Health

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0 250	Continued From page 5 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 Minn. Stat. chapter 144G and Minn. Rules chapter 4659 in place upon licensure and to keep them current as applicable. Page six was electronically signed by O/CNS/LALD-A on November 1, 2023. The licensee had an assisted living license issued on December 1, 2023, with an expiration date of November 30, 2024. The licensee failed to ensure the following policies and procedures were developed and/or implemented: (1) requirements in section 626.557, reporting of maltreatment of vulnerable adults; (2) conducting and handling background studies on employees; (3) orientation, training of staff, and a process for evaluating staff performance; (4) conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified,	0 250			

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0 250	Continued From page 6 managed, and communicated to staff and other health care providers as appropriate; (5) orientation to and implementation of the assisted living bill of rights; (6) infection control practices; (7) conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards; (8) medication and treatment management; (9) delegation of tasks by registered nurses or licensed health professionals; As a result of this survey, the following orders were issued 0510, 0550, 0630, 0640, 0650, 0660, 1290, 1460, 1500, 1620, 1700, 1730, 1750, 1770, 1830, 1880, 1890, 1940, 1970, 2310, and 2320 indicating the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.08 to 144G.95. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 250			
0 470 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 7 on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a staffing plan to determine staffing levels to meet the needs of all residents. In addition, the licensee failed to ensure the staffing schedule was posted as required. 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 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 8 The findings include: The licensee's census was three residents, three of whom received services under the assisted living license. STAFFING PLAN During the entrance conference on August 5, 2024, at 12:04 p.m., owner/clinical nurse supervisor/licensed assisted living director (O/CNS/LALD)-A stated there was one unlicensed personnel (ULP) scheduled for 7:00 a.m. to 3:30 p.m., one ULP scheduled for 3:00 p.m. to 11:30 p.m., and one ULP scheduled from 11:00 p.m. to 7:30 a.m. O/CNS/LALD-A stated the licensee had not developed a written staffing plan but figured one staff member could manage the cares required by the three residents. DAILY STAFF SCHEDULE POSTING During a tour of the facility on August 5, 2024, at 1:03 p.m., a white board was posted in the living room. The board contained the date and stated, "nurse 1, aide 1". O/CNS/LALD-A stated the posting lacked the direct-care staff shifts and hours worked. O/CNS/LALD-A further states she was not aware of the posting requirement. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0180, Subp. 3., effective October 2022, the clinical nurse supervisor (CNS) must develop and implement a written staffing plan that provides an adequate number of qualified direct-care staff to meet the residents' needs 24 hours a day, seven days a week. When developing a direct-care staffing plan, the CNS must ensure that staffing levels are adequate to address the following: A. each resident's needs, as identified in the resident's service plan and assisted living	0 470			

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NAME OF PROVIDER OR SUPPLIER TWIN CITIES NURSING CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 1635 HAZEL STREET NORTH SAINT PAUL, MN 55119			
(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
0 470	Continued From page 9 contract; B. each resident's acuity level, as determined by the most recent assessment or individualized review; C. the ability of staff to timely meet the residents' scheduled and reasonable foreseeable unscheduled needs given the physical layout of the facility premises; D. whether the facility has a secured dementia care unit; and E. staff experience, training, and competency. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0180, Subp. 4., effective October 2022, the CNS must develop a 24-hour daily staffing schedule. The schedule must: (1) include direct-care staff work schedules for each direct-care staff member showing all shifts, including days and hours worked; and (2) identify the direct-care staff member's resident assignments or work location. The daily staffing schedule must be posted, after reacting direct-care staff members' resident assignments, at the beginning of each work shift in a central location in each building of a facility or campus, accessible to staff, residents, volunteers, and the public. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 470			
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according	0 480			

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0 480	Continued From page 10 to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated August 5, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480			
0 485 SS=C	144G.41 Subdivision 1. (13)(i)(A)and(C) 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: (A) menus must be prepared at least one week in	0 485			

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0 485	Continued From page 11 advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes; and (C) the facility cannot require a resident to include and pay for meals in their contract; (ii) weekly housekeeping; (iii) weekly laundry service; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide a menu one week in advance that was made available to all residents. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: During the initial tour on August 5, 2024, at 1:03 p.m. no menu posting was observed. Owner/clinical nurse supervisor/licensed assisted living director (O/CNS/LALD)-A stated the menu was not posted or given to residents as the meals were customized to the residents for what they desired each day. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One	0 485			

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0 485	Continued From page 12 (21) days	0 485			
0 510 SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an infection control program to comply with accepted health care, medical and nursing standards for infection control for one of one employee (unlicensed personnel (ULP)-B) observed to complete a blood sugar check for R2. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).	0 510			

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0 510	Continued From page 13 The findings include: ULP-B started employment on February 25, 2019, under the comprehensive home care license and began providing assisted living services on August 1, 2021. ULP-B's employee record lacked annual competency training to include infection control techniques including a review of hand washing and the need for and use of protective gloves. On August 6, 2024, at 7:25 a.m., the surveyor observed ULP-B apply hand sanitizer and obtained R2's glucometer (a medical device used to measure the amount of sugar in your blood) from the medication cart. ULP-B took a needle and applied to a finger lancet auto injector and placed a glucometer strip in the glucometer machine. ULP-B took an alcohol wipe, the glucometer, and the finger lancet auto injector to R2's room. Without gloves, ULP-B used an alcohol pad to cleanse R2's finger, allowed the area to air dry, then used the finger lancet auto injector and squeezed a small drop of blood from R2's finger. ULP-B then took the glucometer and placed a drop of blood on the strip. Following the procedure, ULP-B removed the strip from glucometer and placed it into the garbage can, removed the used lancet from the auto injector and placed it into a sharps container, put the glucometer back in the medication cart, and washed her hands. ULP-B did not wear gloves during the procedure. Immediately following the observation, the surveyor asked ULP-B about glove use for blood sugar checks and ULP-B stated "sometimes I wear gloves and sometimes not," adding she has difficulty doing the procedure when wearing gloves.	0 510			

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0 510	Continued From page 14 On August 6, 2024, at 9:27 a.m., owner/clinical nurse supervisor/licensed assisted living director (O/CNS/LALD)-A stated staff were trained to wear gloves for any potential body fluid exposure including blood sugar checks. The licensee's undated, Standard Precautions for all Health Care Workers policy included: 1. Assume that blood and all body fluids, with or without visible blood, from all residents are potentially infectious. 3. Gloves, such as vinyl or latex medical gloves, must be worn when cleaning reusable equipment; when having direct contact with blood, body fluids, mucous membranes, or non-intact skin; when handling items soiled with blood; or when handling equipment contaminated with blood or body fluids. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510			
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 email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also	0 550			

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0 550	Continued From page 15 state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post the required information related to the grievance procedure and contact information for the Office of Ombudsman for Long-Term Care and Mental Health and Developmental Disabilities. 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: On August 5, 2024, at 1:03 p.m. the surveyor observed there were no postings of the grievance procedure, the name, telephone number, and e-mail contact information for the individuals who were responsible for handling resident grievances. In addition, there was no evidence of posting of 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 in the common area. On August 5, 2024, at 1:03 p.m. owner/clinical	0 550			

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0 550	Continued From page 16 nurse supervisor/licensed assisted living director (O/CNS/LALD)-A stated the required information regarding the grievance process and the ombudsman contact information was not posted in the common areas of the facility. The licensee's undated, Complaint and Investigation Process policy indicated residents will be informed of their right to complain to the facility about the services received and of the process to follow when making a complaint to the provider. The policy did not include verbiage related to posting the information in a conspicuous place. No further information was provided. 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 as required. This had the potential to affect all of the licensee's current 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	0 570			

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0 570	Continued From page 17 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: During the initial tour on August 5, 2024, at 1:03 p.m., the surveyor did not observe the facility's current license at the main entrance as required. Owner/clinical nurse supervisor/licensed assisted living director (O/CNS/LALD)-A stated the license was kept in her survey binder and was not posted in the facility. O/CNS/LALD-A indicated she was not aware of the posting requirement. No further information provided. 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	0 580			

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0 580	Continued From page 18 by: Based on interview and record review, the licensee failed to implement and maintain a quality management program (QMP) appropriate to the size of the facility and relevant to the type of services provided. This had the potential to affect all current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On August 5, 2024, at 12:04 p.m. during the entrance conference, owner/clinical nurse supervisor/licensed assisted living director (O/CNS/LALD)-A stated the licensee had not created or implemented a QMP for over five years. The licensee's undated, Quality Management Program policy indicated the licensee would develop a continuous quality management program to identify, support and maintain the facility's quality improvement efforts and provide quality services to our residents. Retention of reports and findings will be retained in the facility files for two years and made available to the Minnesota Department of Health upon request. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 580			

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0 630 SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan was developed to include the required content for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2's diagnoses included diabetes, hypertension (high blood pressure), and depression. R2's Service Plan dated May 6, 2019, indicated R2 received services including medication set-up,	0 630			

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0 630	Continued From page 20 medication administration, stand-by assistance for bathing, hygiene/grooming, and dressing. R2's Abuse Prevention Plan: Vulnerability and Safety Assessment dated April 1, 2024, included an assessment of the resident's susceptibility to abuse by other individuals and an assessment of the resident's risk of abusing other vulnerable adults. However, the assessment lacked statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. On August 5, 2024, at 1:39 p.m. owner/clinical nurse supervisor/licensed assisted living director (O/CNS/LALD)-A stated abuse prevention plans should have specific interventions listed for each vulnerability identified. O/CNS/LALD-A stated the required components were lacking from R2's assessment. The licensee's undated, Abuse Prevention Plan policy noted: f. The abuse prevention plan document will identify areas of vulnerability and safety concerns. Interventions to address the areas of concern will be documented on the plan and included on the resident care plan. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630			
0 640 SS=F	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	0 640			

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0 640	Continued From page 21 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; (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 and interview, the licensee failed to support protection and safety by not posting information and phone numbers for reporting to the Minnesota Adult Abuse Reporting Center (MAARC) and 911 emergency number as required. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the facility tour on August 5, 2024, at 1:03 p.m. no posting of the MAARC hotline or 911 phone number was observed. Owner/clinical nurse supervisor/licensed assisted living director (O/CNS/LALD)-A stated the information was not posted and was not aware of the requirement.	0 640			

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0 640	Continued From page 22 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 640			
0 650 SS=D	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; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee records included all required content for one of one employee (unlicensed personnel (ULP)-B).	0 650			

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NAME OF PROVIDER OR SUPPLIER TWIN CITIES NURSING CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 1635 HAZEL STREET NORTH SAINT PAUL, MN 55119			
(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
0 650	Continued From page 23 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-B started employment on February 25, 2019, under the comprehensive home care license and began providing assisted living services on August 1, 2021. ULP-B was an active certified nursing assistant (CNA) on the Minnesota Nurse Aide Registry. On August 6, 2024, at 7:25 a.m., the surveyor observed ULP-B administer medications to R2 in his room. ULP-B's employee record lacked evidence of the following required content: - evidence of current registration or certification; and - documentation of annual performance reviews that identify areas of improvement needed and training needs. On August 6, 2024, at 12:14 p.m. owner/clinical nurse supervisor/licensed assisted living director (O/CNS/LALD)-A stated ULP-B's employee record lacked the required content as noted above. The licensee's undated, Personal Records policy noted the personnel record for an employee shall	0 650			

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0 650	Continued From page 24 include, but not be limited to, the following: 1. Evidence of current professional licensure, registration, or certification. 6. Annual performance evaluation that identifies areas of improvement needed and training needs. No further information was provided. 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 record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) to	0 660			

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0 660	Continued From page 25 include an annual facility TB risk assessment. In addition, the facility failed to ensure TB training was competed for one of one employee (unlicensed personnel (ULP)-B). This had the potential to affect all current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee's current TB Risk Assessment was dated August 1, 2020. ULP-B was hired February 25, 2019, to provide direct care services. ULP-B's employee file lacked documentation of TB training at hire and annually. On August 6, 2024, at 10:33 a.m. owner/clinical nurse supervisor/licensed assisted living director (O/CNS/LALD)-A stated the TB Risk Assessment had not been completed annually as required and was not aware of the requirement. On August 6, 2024, at 12:36 p.m. O/CNS/LALD-A stated ULP-B was lacking documentation of TB training. O/CNS/LALD-A further stated no employees had received TB training. The MN Department of Health Facility	0 660			

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0 660	Continued From page 26 Tuberculosis (TB) Risk Assessment Instructions and Worksheet for Health Care Setting Licensed by MDH updated June 2024, indicated: Settings should perform a facility risk assessment on an annual basis. The worksheet further indicated all Minnesota health care personnel should receive TB education annually, regardless of facility risk level classification. TB education should include information on TB exposure (both occupational and non-occupational) risk factors, the signs and symptoms of TB disease, and TB infection control policies and procedures. The licensee's undated, Tuberculosis Prevention and Control policy included employees of the facility shall be trained regarding TB at time of hire and annually. The policy further directed the facility would complete the community TB risk assessment annually. No further information was provided. 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;	0 680			

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0 680	Continued From page 27 (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to post an emergency disaster plan prominently, provide residents with exit diagrams, and develop an all-hazards risk assessment emergency preparedness (EP) program and plan to include Appendix Z required elements. In addition, the licensee failed to and evaluate it's missing person policy at least quarterly. This had the potential to affect all residents, staff, and visitors of the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: POST AN EMERGENCY DISASTER PLAN	0 680			

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0 680	Continued From page 28 PROMINENTLY During the facility tour on August 5, 2024, at 1:03 p.m. the surveyor observed there was no signage posted, or information regarding the licensee's emergency preparedness plan. On August 5, 2024, at 1:04 p.m. owner/clinical nurse supervisor/licensed assisted living director (O/CNS/LALD)-A stated the EP binder was kept in a locked cabinet and the plan was not posted within the facility. PROVIDE BUILDING EMERGENCY EXIT DIAGRAMS TO ALL RESIDENTS During the initial tour on August 5, 2024, at 1:03 p.m. the surveyor observed there was no signage on the inside of the resident doors or inside the licensee's admission packet with emergency exit diagrams. On August 5, 2024, at 1:04 p.m. O/CNS/LALD-A stated emergency exit diagrams were not provided to residents, but diagrams were posted on the wall by the front and back door. O/CNS/LALD-A indicated she was not aware of the requirement. EMERGENCY PREPAREDNESS PLAN CONTENT The licensee's EP plan consisted of several undated, documents and policies in a red three-ringed binder. The book included various policies/procedures related to weather events, water shortage, fire, missing person, and a bomb threat. The licensee lacked a customized EP plan to include the following required content:	0 680			

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0 680	Continued From page 29 - Hazard vulnerability assessment; - A description of the population served by licensee and succession planning; - A process for EP collaboration with State and local EP officials/organizations; - Development of all policies/procedures, based on assessment; and additional policies for: - Subsistence needs for staff and residents during an emergency to include (food, water, medical supplies, pharmacy supplies, sewer and waste disposal, emergency lighting, fire detection, extinguishing and alarm systems); - Policy/procedure for tracking staff and residents; - Policy/procedure to address safe evacuation from the facility to include (transportation and identification of evacuation location(s); - Policy/procedure for sheltering in place; - Policy/procedure to address system of medical documentation that preserves resident information, protects confidentiality, and secure/maintains availability of records; - Policy/procedure to address use of volunteers, including the process/role for integration; - Policy/procedure to include pre-arranged transfer agreements with other facilities; - Policy/procedure to address role of facility under a waiver declared by the Secretary in accordance with section 1135 of the Act; - A communication plan that contains how the facility coordinates resident care within the facility, across healthcare providers, and with state and local public health departments; - Communication plan that includes names and contact information for staff, resident physicians, other facilities, volunteers; - Communication plan that includes contact information for federal, state, tribal, local EP staff, ombudsman, state licensing and certification agencies; - Communication plan including primary and	0 680			

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0 680	Continued From page 30 alternate means for communication; - Communication plan that includes methods for sharing information for residents under the facility's care, as necessary, with other health providers to maintain continuity of care; - Communication plan that includes a means to provide information regarding the facility's needs, and its ability to provide assistance to include information about their occupancy; - Method for sharing info/notifications with family; - Policy/procedure for EP training and testing program; - Initial and annual training program for staff; and - Annual EP testing requirements to include the facility conducted and/or participated in a full-scale community-based exercise or tabletop exercise to test its plan and document the results of the testing at least twice annually as required. MISSING RESIDENT PLAN/POLICY The licensee's undated, Missing Resident policy was included in the EP plan. The policy lacked evidence the assisted living director and clinical nurse supervisor reviewed or updated the policy and documented any changes, at least quarterly as required per Assisted Living Facilities: Minnesota Rules Chapter 4659.0110 Subp. 4. On August 6, 2024, at 1:17 p.m. O/CNS/LALD-A stated the licensee's EP plan lacked the above required components. O/CNS/LALD-A further stated she was aware of the EP plan requirements but had not completed it for the facility. O/CNS/LALD-A further stated the missing resident policy had not been reviewed or updated quarterly as required. The licensee's undated, Emergency Management policy noted the facility would have an identified	0 680			

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0 680	Continued From page 31 plan in place to ensure the safety and well-being of residents and employees during periods of an emergency or a disaster that disrupts facility services. Per Assisted Living Facilities: Minnesota Rules Chapter 4695, 4659.0100, sections A and B, assisted living facilities shall comply with the federal emergency preparedness regulations for long-term care facilities under Code of Federal Regulations, title 42, section 483.73, or successor requirements. This part references documents, specifications, methods, and standards in "State Operations Manual Appendix Z - Emergency Preparedness for All Providers and Certified Supplier Types: Interpretive Guidance," which is incorporated by reference. Per Assisted Living Facilities: Minnesota Rules Chapter 4659, 4659.0110, Subp. 4. Review missing resident plan. The assisted living director and clinical nurse supervisor must review the missing person plan at least quarterly and document any changes to the plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			
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:	0 780			

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0 780	Continued From page 32 (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 provide smoke alarms that complied with fire protection requirements. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On August 6, 2024, at 2:00 p.m., survey staff	0 780			

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0 780	Continued From page 33 toured the facility with clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A. During the tour, the surveyor observed the following: - A smoke alarm was not installed in the basement. During the facility tour interview, CNS/LALD-A verified a smoke alarm was not provided in the basement. - When smoke alarms were tested in resident bedrooms and outside the bedrooms, none of the other smoke alarms in the dwelling unit were actuated. During the facility tour interview, CNS/LALD-A verified the dwelling unit smoke alarms were not interconnected as required by statute. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780			
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee	0 790			

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0 790	Continued From page 34 failed to install and maintain portable fire extinguishers as required by statute. This deficient condition 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 of the residents). The findings include: On August 6, 2024, at 2:00 p.m., survey staff toured the facility with clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A. During the tour, the surveyor observed the following: - The installed fire extinguishers were rated 1-A:10-B:C. During the facility tour interview, CNS/LALD-A verified these fire extinguishers did not meet the minimum rating. - One fire extinguisher in the kitchen was stored on the kitchen counter. During the facility tour interview, CNS/LALD-A stated this was a spare and verified it was not properly installed. When provided in the facility, fire extinguishers must be mounted to prevent them from being moved or damaged. - Tags or labels were not attached to the portable fire extinguishers showing annual maintenance inspections had been performed by certified service personnel. - Tags or labels were not attached to the portable fire extinguishers showing monthly inspections had been completed. Fire extinguisher inspections must be conducted every month to	0 790			

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0 790	Continued From page 35 ensure that each extinguisher is in its designated place, that it has not been tampered with, and that there is no obvious physical damage or condition that would interfere with its use or operation. During the facility tour interview, CNS/LALD-A verified the required annual and monthly inspections had not been completed. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790			
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 provide the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. 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	0 800			

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0 800	Continued From page 36 or has the potential to affect a large portion or all of the residents). The findings include: On August 6, 2024, at 2:00 p.m., survey staff toured the facility with clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A. During the tour, the surveyor observed the following: - In resident room 2, the path to the egress window was obstructed by personal items stored in front of the window which could delay exiting in the event of an emergency. During the facility tour interview, CNS/LALD-A verified the improper placement of these personal items. - In resident room 2, the wall behind the bed was soiled. During the facility tour interview, CNS/LALD-A stated the soiling on the wall was a result of resident behavioral issues. - In resident room 3, part of the wood frame was broken for the bedroom door. - In the shared resident bathroom, the bathtub basin surface was peeling and the caulking installed around the bathtub surfaces had separated. - On the exterior of the facility, the gutters installed on the front of the home were filled with vegetative debris. Two downspouts were crushed on the ends reducing the opening where water drains out for the gutter system. All components of a gutter system must be maintained to ensure water properly drains away from the basement and foundation of the home. During the facility tour interview, CNS/LALD-A verified the above listed observations required maintenance and repair. TIME PERIOD FOR CORRECTION: Seven (7)	0 800			

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0 800	Continued From page 37	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 evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill.	0 810			

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0 810	Continued From page 38 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop a fire safety and evacuation plan with the required content, make the plan readily available, and provide required training and drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On August 6, 2024, at 2:00 p.m., survey staff toured the facility with clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A. During the tour, the surveyor observed the posted floor plan did not identify the basement. Accurate floor plans are required to be included as part of the facility fire safety and evacuation plan to provide efficient communication in the event of a fire or similar emergency. During the facility tour interview, CNS/LALD-A verified the floor plan required revision. On August 6, 2024, CNS/LALD-A provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. During an interview on August 6, 2024, at 3:15 p.m., CNS/LALD-A stated the FSEP was stored in a locked cabinet in the living room on the main	0 810			

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0 810	Continued From page 39 floor. The FSEP was not located in a central location for all staff accessibility. FIRE SAFETY AND EVACUATION PLAN The licensee had not developed and maintained a FSEP evident by a record review of the available documentation. The FSEP included a 7.05 fire safety policy from a third-party provider. This FSEP fire safety policy inaccurately referenced smoke compartment doors, fire sprinklers, and doors on magnetic holders. The 7.05 fire safety policy was a template designed for a building with life safety systems or a fire-resistant construction type. The FSEP failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks evident by a lack of these actions in the plan. The FSEP failed to include specific fire protection procedures necessary for residents evident by the lack of these procedures in the plan. The FSEP failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents evident by the lack of these procedures in the plan. During an interview on August 6, 2024, at 3:15 p.m., CNS/LALD-A verified the FSEP required revision. TRAINING Record review indicated the licensee failed to provide fire safety and evacuation training to residents at least once per year evident by no	0 810			

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0 810	Continued From page 40 training records. Record review indicated the licensee failed to provide training to employees on the FSEP upon hire and/or at least twice per year evident by no training records. During an interview on August 6, 2024, at 3:15 p.m., CNS/LALD-A stated no training records were available. DRILLS Record review indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month evident by no drill records. During an interview on August 6, 2024, at 3:15 p.m., CNS/LALD-A stated no drill records were available. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810			
0 820 SS=H	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to	0 820			

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0 820	Continued From page 41 correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide a compliant egress window in one occupied resident bedroom. This had the potential to directly affect one resident and all staff. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On August 6, 2024, at 2:00 p.m., survey staff toured the facility with clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A. The egress windows in resident bedrooms were opened by CNS/LALD-A. Survey staff measured the clear openable area of the windows. The window in bedroom 2 did not meet the minimum requirements for safe egress. Egress window measurements: Occupied resident bedroom 2 - the clear openable area of the window measured 24.5 inches width, 22.5 inches height, total clear area of 551.25 square inches. One window in each resident bedroom must meet the minimum window opening size of at least 20 inches in width and, a minimum height of 20 inches, with a total clear area of at least 648 square inches (4.5 square feet). During the facility tour interview, CNS/LALD-A	0 820			

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0 820	Continued From page 42 verified the egress window measurements. TIME PERIOD FOR CORRECTION: Immediate	0 820			
0 950 SS=C	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by:	0 950			

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0 950	Continued From page 43 Based on interview and record review, the licensee failed to provide the required notice for right to a designated representative on a document separate from the contract for one of one resident (R2). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: R2's record lacked evidence in writing of providing on a document separate from the contact verbatim notice of "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 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." R2's Resident Contract for Assisted Living dated April 1, 2024, included a name/address/email/telephone number line to identify a designated representative and a line to initial if the resident declined to name a designated representative; however, the designated representative information was filled	0 950			

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0 950	Continued From page 44 out with R2's information and the line to initial if the resident declined to name a designated representative was blank. In addition, it lacked the required statutory language provided on a form separate from the contract. On August 5, 2024, at 1:33 p.m. owner/clinical nurse supervisor/licensed assisted living director (O/CNS/LALD)-A stated the right to designate a representative statutory language was not present in the current assisted living contract. O/CNS/LALD-A stated she was not aware of the requirement, and further stated all residents were provided the same contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 950			
01290 SS=D	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith 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.	01290			

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01290	Continued From page 45 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a background study was submitted and received in affiliation with the assisted living license for one of one employee (unlicensed personnel (ULP)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-B started employment on February 25, 2019, under the comprehensive home care license and began providing assisted living services on August 1, 2021. On August 6, 2024, at 7:25 a.m., the surveyor observed ULP-B administer medications to R2 in his room. ULP-B's employee record contained a Background Study Clearance dated February 25, 2019, for a separate license previously operated by the licensee's owner. ULP-B's employee record lacked evidence the licensee affiliated a background study for their current assisted living license. On August 6, 2024, at 12:01 p.m., owner/clinical nurse supervisor/licensed assisted living director (O/CNS/LALD)-A stated ULP-B's background	01290			

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01290	Continued From page 46 study had not been affiliated with the assisted living facility license. The licensee's undated, Background Studies policy noted each facility employee/volunteer or contractor who will provide direct care to residents must have a background study completed. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	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 observation, interview, and record review, the licensee failed to ensure one of one employee (unlicensed personnel (ULP)-B) completed an orientation to assisted living facility licensing requirements and regulations before providing services to 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	01460			

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01460	Continued From page 47 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-B was hired on February 25, 2019, to provide direct care and services to the licensee's residents under the comprehensive home care license and under the assisted living care license on August 1, 2021. On August 6, 2024, at 7:25 a.m., the surveyor observed ULP-B administer medications to R2 in his room. ULP-B's employee record lacked evidence of orientation to assisted living regulations for the following topics: - Overview of Assisted Living statutes; - Review of provider's policies and procedures; - Handling emergencies and using emergency services; - Reporting maltreatment of vulnerable adults or minors; - Assisted Living Bill of Rights; - Principles of person-centered planning/service delivery; - Handling of resident complaints, reporting of complaints, where to report; - Consumer advocacy services; and - Review of types of Assisted Living services the employee will provide and provider's scope of license. On August 6, 2024, at 12:02 p.m. owner/clinical nurse supervisor/licensed assisted living director (O/CNS/LALD)-A stated none of the licensee's	01460			

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01460	Continued From page 48 current employees had received orientation to assisted living facility licensing requirements training, further indicating she was not aware of the requirement. The licensee's undated, Facility Employee Orientation policy noted all employees of the assisted living facility, including those who provide direct care, supervision of direct care, or management of services for the facility, shall complete an orientation on topics required by Minnesota statutes and rules for assisted living. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01460			
01500 SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor	01500			

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01500	Continued From page 49 blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	01500			

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01500	Continued From page 50 review, the licensee failed to ensure annual training included all required topics for each 12 months of employment for one of one employee (unlicensed personnel (ULP)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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 started employment on February 25, 2019, under the comprehensive home care license and began providing assisted living services on August 1, 2021. On August 6, 2024, at 7:25 a.m., the surveyor observed ULP-B administer medications to R2 in his room. ULP-B's employee record lacked documented evidence of the following required annual training: - training on reporting of maltreatment of vulnerable adults under section 626.557; - review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; - review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor	01500			

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NAME OF PROVIDER OR SUPPLIER TWIN CITIES NURSING CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 1635 HAZEL STREET NORTH SAINT PAUL, MN 55119			
(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
01500	Continued From page 51 blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; - effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; - review of provider's policies and procedures; and - principles of person-centered planning and service delivery. On August 6, 2024, at 12:16 p.m., owner/clinical nurse supervisor/licensed assisted living director (O/CNS/LALD)-A stated ULP-B had not completed any annual training. O/CNS/LALD-A further stated none of the licensee's employees would have annual training in their files as she had not required this. The licensee's undated, Annual Training Requirements policy noted all staff that provide direct care services in assisted living must complete at least eight hours of annual training for each 12 months of employment. Annual training must include: 1. Training on reporting of maltreatment of vulnerable adults under section 626.557; 2. Review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; 3. Review of infection control techniques used in the home and implementation of infection control standards including: a. a review of hand-washing techniques; b. need for and use of protective glove, gown, and masks; c. appropriate disposal of contaminated materials and equipment, such as dressings,	01500			

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01500	Continued From page 52 needles, syringes and razor blades; d. disinfecting environmental surfaces; f. Reporting of communicable diseases; 4. Effective approaches to use to problem solve when working with a residents challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease or related disorders; 5. Review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; 6. The principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500			
01530 SS=F	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another	01530			

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01530	Continued From page 53 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 observation, interview, and record review, the licensee failed to ensure one of one employee (unlicensed personnel (ULP)-B) received the required amount of dementia care training in the required time frame. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee provided services under an Assisted Living license. ULP-B started employment on February 25, 2019, under the comprehensive home care license and began providing assisted living services on August 1, 2021.	01530			

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01530	Continued From page 54 On August 6, 2024, at 7:25 a.m., the surveyor observed ULP-B administer medications to R2 in his room. ULP-B's employee record lacked documented evidence the employee received the required eight hours of dementia care training within 160 working hours of the employment start date. On August 6, 2024, at 12:45 p.m., owner/clinical nurse supervisor/licensed assisted living director (O/CNS/LALD)-A stated none of the licensee's staff would have dementia care training. O/CNS/LALD-A stated she was not aware of the dementia care training requirement as she thought it was only for assisted living facilities with dementia care. The licensee's undated, Dementia Care Training policy noted all assisted living facilities must meet the following training requirements: 1. Supervisors of direct-care staff must have at least eight hours of initial training within 120 working hours of employment start dated and must have at least two hours of training on topics related to dementia care for each 12 months of employment. 2. Direct care employees must have completed at least eight hours of initial training on required topics in the 160 hours from employment. Until this training is complete, the employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training related to dementia care and who can act as a resource and assist if issues arise. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One	01530			

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01530	Continued From page 55 (21) days	01530			
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the nurse completed ongoing resident reassessments that did not exceed 90 days for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or	01620			

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01620	Continued From page 56 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: R2's diagnoses included diabetes, hypertension (high blood pressure), and depression. R2's Service Plan dated May 6, 2019, indicated R2 received services including medication set-up, medication administration, stand-by assistance for bathing, hygiene/grooming, and dressing. R2's last three assessments were requested. Assessments completed November 30, 2023, February 1, 2024, and April 1, 2024, were provided. R2's record lacked evidence of additional comprehensive nursing assessments after the April 1, 2024, assessment had been completed. On August 5, 2024, at 2:02 p.m. owner/clinical nurse supervisor/licensed assisted living director (O/CNS/LALD)-A stated R2's last assessment was greater than 90 days ago indicating she had not completed an assessment of R2 since April 1, 2024. The licensee's undated, Nursing Assessment and Reassessment of Residents policy noted on-going reassessment and monitoring will be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last assessment.	01620			

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01620	Continued From page 57 No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620			
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a written service plan was revised to reflect the current services provided for one of one resident (R2). This practice resulted in a level two violation (a	01640			

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01640	Continued From page 58 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On August 6, 2024, at 7:25 a.m. the surveyor observed unlicensed personnel (ULP)-B check R2's blood sugar. R2's diagnoses included diabetes. R2's Service Plan dated May 6, 2019, indicated R2 received services including medication set-up, medication administration, stand-by assistance for bathing, hygiene/grooming, and dressing. The service plan did not include blood sugar checks. R2's most recent prescriber orders dated February 28, 2023, included orders to check a fasting blood sugar each morning and two hours after each meal three times daily. R2's Medication Administration Record (MAR) dated August 1, 2024, through August 6, 2024, indicated R2 received blood sugar checks twice daily as needed at 7:00 a.m. and 3:00 p.m. The MAR included staff initials and blood sugar results for each day. On August 6, 2024, at 10:06 a.m. owner/clinical nurse supervisor/licensed assisted living director (O/CNS/LALD)-A stated R2's service plan lacked the treatment of blood sugar checks, and it should have been included.	01640			

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01640	Continued From page 59 The licensee's undated, Service Plan policy noted: 4. The service plan will include: a. a description of the services to be provided. 8. The resident shall be advised, orally and in writing, of any changes in type or frequency of services or fee schedule. This advisement shall occur as soon as possible after the facility becomes aware of the change. Written notice will be given by making the appropriate change on the service plan and obtaining resident/representative signature or initials. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640			
01700 SS=D	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues.	01700			

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01700	Continued From page 60 (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted a face-to-face medication management assessment to include all required content for one of one resident (R2) who received medication management services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on August 5, 2024, at 12:04 p.m., owner/clinical nurse supervisor/licensed assisted living director (O/CNS/LALD)-A stated the licensee provided medication management services to residents at the facility.	01700			

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01700	Continued From page 61 R2's diagnoses included diabetes, hypertension (high blood pressure), and depression. On August 6, 2024, at 7:25 a.m., the surveyor observed unlicensed personnel (ULP)-B administer medications to R2 in his room. R2's Service Plan dated May 6, 2019, indicated R2 received services including medication set-up and medication administration. R2's most recent prescriber orders dated February 28, 2023, included orders for two insulins, one supplement, one blood thinner, two for diabetes, three for blood pressure, one for depression, one for reflux, and one for extra fluid. R2's Medication Administration Record (MAR) dated August 1, 2024, through August 6, 2024, included medications as prescribed, times to administer, and staff initials to indicate the medications had been given. R2's record included a Medication Management Services- Addendum to Service Plan document dated April 1, 2024, that identified the RN had assessed the need for medication administration and indications for medications; however, R2's record lacked evidence the RN conducted a face-to-face review of all medications R2 was known to be taking to include: - side effects; - contraindications; - allergic or adverse reactions; and - actions to address these issues. In addition, R2's record did not identify interventions needed in the management of medications to prevent diversion of medications by the resident or others who may have access to the medications.	01700			

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01700	Continued From page 62 On August 6, 2024, at 10:01 a.m., O/CNS/LALD-A stated she had not completed a medication assessment with the required content. O/CNS/LALD-A indicated she had left the required components as noted above unanswered on the Medication Management Services- Addendum to Service Plan document. The licensee's undated, Individualized Medication Management Plan and Record policy noted following completion of the nursing assessment, including an assessment of the resident's need for medication management, the RN develops an individualized medication management record for the resident in conjunction with the resident and/or the resident's representative. The licensee's undated, Medication Management Services policy included: 7. The RN or licensed practical nurse (LPN) will review each resident's medication record when the nurse is setting up medications and at other appropriate times based on the resident's needs and the resident's medication management services, including during the resident monitoring visit: c. To observe for signs of medication diversion; d. To evaluate the effectiveness of the medications and identify any drug-drug interaction, and untoward or reported side effects. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01700			

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01730	Continued From page 63	01730			
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes.	01730			

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01730	Continued From page 64 (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a current individualized medication management plan to include all required content for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on August 5, 2024, at 12:04 p.m., owner/clinical nurse supervisor/licensed assisted living director (O/CNS/LALD)-A stated the licensee provided medication management services to residents at the facility. R2's diagnoses included diabetes, hypertension (high blood pressure), and depression. On August 6, 2024, at 7:25 a.m., the surveyor observed unlicensed personnel (ULP)-B administer medications to R2 in his room. R2's Service Plan dated May 6, 2019, indicated	01730			

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NAME OF PROVIDER OR SUPPLIER TWIN CITIES NURSING CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 1635 HAZEL STREET NORTH SAINT PAUL, MN 55119			
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01730	Continued From page 65 R2 received services including medication set-up and medication administration. R2's most recent prescriber orders dated February 28, 2023, included orders for two insulins, one supplement, one blood thinner, two for diabetes, three for blood pressure, one for depression, one for reflux, and one for extra fluid. R2's Medication Administration Record (MAR) dated August 1, 2024, through August 6, 2024, included medications as prescribed, times to administer, and staff initials to indicate the medications had been given. R2's record lacked a medication management plan to include: - procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services. On August 6, 2024, at 10:02 a.m., O/CNS/LALD-A stated R2's record lacked the above noted content. The licensee's undated, Individualized Medication Management Plan and Record policy noted following completion of the nursing assessment, including an assessment of the resident's need for medication management, the registered nurse (RN) develops an individualized medication management record for the resident in conjunction with the resident and/or the resident's representative. The plan must include the following: f. Procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services.	01730			

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01730	Continued From page 66 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730			
01750 SS=D	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure delegated procedures were followed by one of one unlicensed personnel (ULP-B) observed during medication administration. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).	01750			

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01750	Continued From page 67 The findings include: R2's diagnoses included diabetes. R2's Service Plan dated May 6, 2019, indicated R2 received services including medication administration. R2's prescriber orders March 1, 2023, included Novolog FlexPen (fast-acting insulin) 100 units/milliliter (ml), inject eight units subcutaneously (under the skin) three times daily before meals. On August 6, 2024, at 7:25 a.m. unlicensed personnel (ULP)-B was observed to obtain R2's Novolog FlexPen, remove the cap, and secure a needle onto the hub of the FlexPen. ULP-B then dialed the FlexPen to eight units and handed the FlexPen to R2. R2 completed his own insulin injection into his left abdomen. R2 then handed the insulin FlexPen back to ULP-B in which the needle was removed and disposed of into a sharps container. ULP-B did not use an alcohol swab to cleanse the hub of the FlexPen prior to applying a new needle and did not prime the pen by wasting two units after the new needle was applied. ULP-B stated the process she followed is how she was trained by the registered nurse (RN). On August 6, 2024, at 9:26 a.m. owner/clinical nurse supervisor/licensed assisted living director (O/CNS/LALD)-A stated she was not aware the needle hub should be cleansed prior to applying a new needle and was not aware the FlexPen required a two unit waste prior to dialing the prescribed insulin amount. O/CNS/LALD-A stated manufacturer instructions should be	01750			

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01750	Continued From page 68 followed for FlexPen use. Novolog FlexPen instructions for use dated revised February 2023, noted: A. Pull off the pen cap, wipe the rubber stopper with an alcohol swab. B. Remove the protective tab from a disposable needle. Screw the needle tightly onto your FlexPen. C. Pull off the big outer needle cap D. Pull off the inner needle cap and throw it away. E. Turn the dose selector to select 2 (two) units. F. Hold your Novolog FlexPen with the needle pointing up. Tap the cartridge gently with your finger a few times to make any air bubbles collect at the top of the cartridge. G. Keep the needle pointing upwards, press the push-button all the way in. The dose selector returns to 0 (zero). A drop of insulin should appear at the needle tip. If not, change the needle and repeat the procedure no more than 6 (six) times. If you do not see a drop of insulin after 6 (six) times, do not use the Novolog FlexPen. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750			
01770 SS=F	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup.	01770			

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01770	Continued From page 69 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure documentation of medication set-up included all the required content for one of one resident (R2) receiving medication set-up. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on August 5, 2024, at 12:04 p.m., owner/clinical nurse supervisor/licensed assisted living director (O/CNS/LALD)-A stated the licensee provided medication management services to residents at the facility, including medication set-up. R2's diagnoses included diabetes, hypertension (high blood pressure), and depression. R2's Service Plan dated May 6, 2019, indicated R2 received services including medication set-up and medication administration. R2's most recent prescriber orders dated February 28, 2023, included: - aspirin (heart health supplement) 81 milligrams (mg) by mouth daily; - Brilinta (prevents blood clots from forming) 90	01770			

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01770	Continued From page 70 mg by mouth twice daily; - glipizide (for diabetes) 5 mg by mouth twice daily before meals; - lisinopril (for blood pressure) 5 mg by mouth daily; - metformin (for diabetes) 1,000 mg by mouth twice daily before meals; - metoprolol (for blood pressure) 12.5 mg by mouth daily; - mirtazapine (for depression) 15 mg by mouth every bedtime; - pantoprazole (for reflux) 40 mg by mouth daily; - spironolactone (removes extra fluid) 12.5 mg by mouth daily; - torsemide (removes extra fluid) 20 mg by mouth in the afternoon; - torsemide 40 mg by mouth every morning; - Lantus SoloStar (long-acting insulin) 100 units (u)/1 milliliter (ml) inject 35 units subcutaneously every evening; - Novolog FlexPen (fast-acting insulin) 100 u/1 ml inject 8 units subcutaneously three times daily before meals. R2's record lacked documentation by the licensed nurse at the time of setup to include the name of medication, quantity of dose, times to be administered, and route of administration. On August 5, 2024, at 1:50 p.m., owner/clinical nurse supervisor/licensed assisted living director (O/CNS/LALD)-A stated she completed a weekly medication set-up into a dosage box for R2. O/CNS/LALD-B stated she followed R2's medication profile and the pre-packaged medications from pharmacy to complete the medication set-up but did not document the name of the medication, quantity of dose, times to be administered, or route of administration anywhere in the resident record. In addition,	01770			

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01770	Continued From page 71 O/CNS/LALD-A stated she did this for all three of the licensee's residents adding she didn't think she would need to document the medication set-up since the medications were prepackaged from the pharmacy. The licensee's undated, Medication Set up policy indicated staff setting up medications would follow accepted standards of practice and a medication administration record (MAR), or other medication documentation method should be used to set up the medications. No further information was provided. TIME PERIOD TO CORRECT: Seven (7) Days	01770			
01830 SS=D	144G.71 Subd. 14 Renewal of prescriptions Prescriptions must be renewed at least every 12 months or more frequently as indicated by the assessment in subdivision 2. Prescriptions for controlled substances must comply with chapter 152. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to renew prescriptions at least every 12 months for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or	01830			

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01830	Continued From page 72 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on August 5, 2024, at 12:04 p.m., owner/clinical nurse supervisor/licensed assisted living director (O/CNS/LALD)-A stated the licensee provided medication management services to residents at the facility. R2's diagnoses included diabetes, hypertension (high blood pressure), and depression. On August 6, 2024, at 7:25 a.m., the surveyor observed unlicensed personnel (ULP)-B administer medications to R2 in his room. R2's Service Plan dated May 6, 2019, indicated R2 received services including medication set-up and medication administration, R2's most recent prescriber orders dated February 28, 2023, included orders for two insulins, one supplement, one blood thinner, two for diabetes, three for blood pressure, one for depression, one for reflux, and one for extra fluid. R2's Medication Administration Record (MAR) dated August 1, 2024, through August 6, 2024, included medications as prescribed, times to administer, and staff initials to indicate the medications had been given. On August 6, 2024, at 9:44 a.m., O/CNS/LALD-A stated R2 lacked current prescriber orders. O/CNS/LALD-A further stated R2 had went to a licensed prescriber a few weeks ago but did not bring back any paperwork.	01830			

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01830	Continued From page 73 The licensee's undated, Medication Prescriptions and Refills policy noted a current, written prescriber's prescription must be obtained for any medication, including an over-the-counter medication, whenever staff is responsible for setting up the medication, administering the medication or providing other medication management services for a resident. The registered nurse (RN) or licensed practical nurse (LPN) will assure that the prescriber renews a medication order at least every 12 months. No further information. TIME PERIOD OF CORRECTION: Seven (7) days	01830			
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were stored according to the manufacturer's recommendations for the licensee's one resident (R2) with insulin. 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	01880			

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01880	Continued From page 74 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: R2's prefilled insulin pen was not stored according to manufacturer's recommendations. R2's diagnosis included diabetes. R2's Service Plan dated May 6, 2019, indicated R2 received services including medication administration. R2's Medication Assessment/Delegation Form dated April 1, 2024, identified R2 required staff to assist with medications including daily insulin administration. R2's Medication Management Services - Addendum to Service Plan dated April 1, 2024, identified R2 required assistance with storage, delegation of medication administration and documentation of medication administration. On August 6, 2024, at 7:25 a.m. unlicensed personnel (ULP)-B was observed to obtain R2's scheduled Novolog FlexPen (a rapid-acting insulin) from the locked refrigerator and stated that is where both in-use and extra insulin was kept for R2. ULP-B secured a new needle to the FlexPen, dialed the pen to eight units, and handed the insulin pen to R2. R2 administered his own insulin injection into his left abdomen. R2 then handed the FlexPen back to ULP-B in which the needle was removed and disposed of in a sharps container. ULP-B then placed the insulin pen back into the refrigerator.	01880			

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01880	Continued From page 75 On August 6, 2024, at 9:18 a.m. owner/clinical nurse supervisor/licensed assisted living director (O/CNS/LALD)-A stated R2 was the only resident with insulin, but both extra and in-use insulin pens were stored in the refrigerator. O/CNS/LALD-A was not aware of the manufacturer storage instructions for Novolog FlexPens but stated medications should be stored per manufacturer instructions. Novolog FlexPen Instructions for use revised February 2023, included: store the FlexPex you are currently using out of the refrigerator at room temperature below 86 degrees Fahrenheit (F) for up to 28 days. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880			
01890 SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to date time sensitive medications with an open date for the licensee's one resident (R2) receiving insulin.	01890			

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01890	Continued From page 76 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: On August 6, 2024, at 7:25 a.m. unlicensed personnel (ULP)-B was observed to obtain R2's Novolog FlexPen (a rapid-acting insulin) for the scheduled morning administration. R2's Novolog FlexPen 100 units/milliliter (ml), lacked a label to indicate when the insulin pen was opened and when the insulin pen would expire. ULP-B stated she would not write a date opened or date of expiration on the insulin, further indicating it wouldn't expire based on the amount R2 used each day. On August 6, 2024, at 9:18 a.m., owner/clinical nurse supervisor/licensed assisted living director (O/CNS/LALD)-A stated the FlexPen should be dated when opened. Novolog FlexPen Instructions for use revised February 2023, included: The Novolog FlexPen you are using should be thrown away after 28 days, even if it still has insulin left in it. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890			

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01940	Continued From page 77	01940			
01940 SS=F	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for the	01940			

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01940	Continued From page 78 licensee's one resident (R2) receiving treatments. 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: On August 6, 2024, at 7:25 a.m., the surveyor observed unlicensed personnel (ULP)-B check R2's blood sugar. R2 was admitted on May 6, 2019, with diagnoses that included diabetes. R2's Service Plan dated May 6, 2019, indicated R2 received services including medication set-up, medication administration, stand by assistance for bathing, hygiene/grooming, and dressing. The service plan did not include blood sugar checks. R2's most recent prescriber orders dated February 28, 2023, included orders to check fasting blood sugar each morning and two hours after each meal three times daily. R2's Medication Administration Record (MAR) dated August 1, 2024, through August 6, 2024, indicated R2 received blood sugar checks twice daily as needed at 7:00 a.m. and 3:00 p.m. The MAR included staff initials and blood sugar results for each day. R2's record lacked a treatment management plan to include the following required content for blood	01940			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31262	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/07/2024
NAME OF PROVIDER OR SUPPLIER TWIN CITIES NURSING CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1635 HAZEL STREET NORTH SAINT PAUL, MN 55119		
(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
01940	Continued From page 79 sugars: - documentation of specific resident instructions relating to the treatments or therapy administration; - identification of treatment or therapy tasks that will be delegated to unlicensed personnel; - procedures for notifying a registered nurse when a problem arose with treatments or therapy services; and - any resident specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed and monitoring of treatment or therapy to prevent possible complications or adverse reactions. On August 6, 2024, at 10:33 a.m., owner/clinical nurse supervisor/licensed assisted living director (O/CNS/LALD)-A stated R2's individualized treatment plan lacked the required content as noted above. The licensee's undated, Treatment and Therapy Management Plan policy indicated when the resident has been assessed and orders for treatments and therapies are obtained, an individualized treatment/therapy plan and management record will be developed. The plan will include the following: b. Documentation of specific instructions that relate to providing the treatments or therapy administration; c. Identification of treatment or therapy tasks that will be delegated to unlicensed personnel; d. Procedures for notifying a registered nurse or other licensed health professional if problems arise with the treatment or therapy services; e. Any resident-specific requirements that relate to documentation of treatments and therapy, and direction on where tasks are to be documented;	01940			

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01940	Continued From page 80 and g. Verification by the registered nurse that services are administered as prescribed and monitoring of treatment or therapy to prevent complications or adverse reactions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940			
01970 SS=F	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure up-to-date written or electronically recorded orders were maintained for the licensee's one resident (R2) receiving treatments. 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).	01970			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01970	Continued From page 81 The findings include: On August 6, 2024, at 7:25 a.m., the surveyor observed unlicensed personnel (ULP)-B check R2's blood sugar. R2 was admitted on May 6, 2019, with diagnosis that included diabetes. R2's Service Plan dated May 6, 2019, indicated R2 received services including medication set-up, medication administration, stand by assistance for bathing, hygiene/grooming, and dressing. The service plan did not include blood sugar checks. R2's Medication Administration Record (MAR) dated August 1, 2024, through August 6, 2024, indicated R2 received blood sugar checks twice daily as needed at 7:00 a.m. and 3:00 p.m. The MAR included staff initials and blood sugar results for each day. R2's most recent prescriber orders dated February 28, 2023, (greater than 12 months ago) included orders to check fasting blood sugar each morning and two hours after each meal three times daily. On August 6, 2024, at 11:08 a.m., owner/clinical nurse supervisor/licensed assisted living director (O/CNS/LALD)-A stated R2's prescriber orders were greater than 12 months ago, and the record lacked current prescriber orders for the blood sugar checks. O/CNS/LALD-A stated she would need to obtain current prescriber orders for the blood sugar checks. The licensee's undated, Treatment and Therapy Management Plan policy indicated orders must	01970			

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01970	Continued From page 82 be written or electronically recorded from an authorized prescriber for all treatments and therapies. Treatment and therapy orders must be renewed at least every 12 months. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970			
02310 SS=I	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the care and services were provided according to acceptable health care, medical, or nursing standards for three of three residents (R2, R4, R3) with bed rails. This resulted in an immediate correction order on August 6, 2024. In addition, the licensee failed to ensure oxygen cylinders were secured in a rack to prevent tipping or damage for one of one resident (R3). This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that	02310			

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02310	Continued From page 83 has affected or has potential to affect a large portion or all the residents). The findings include: R2 On August 6, 2024, at 7:25 a.m. R2's room was observed to have a hospital bed with bilateral bed rails in the raised position. Unlicensed personnel (ULP)-B stated R2 was able to transfer independently and was not sure if he utilized the bed rails. R2's diagnoses included hypertension (high blood pressure) and diabetes. R2's Service Plan dated May 16, 2019, indicated R2 received services including medication administration, housekeeping, laundry, and standby assistance with bathing, dressing, and grooming. R2's assessment dated January 1, 2024, did not include measurements of the bed rail zones of entrapment or documentation of education on the risk vs benefits of bed rail use. R4 On August 6, 2024, at 8:55 a.m. R4's room was observed to have a hospital bed with bilateral bed rails in the lowered position. R4 stated the bed rails were normally in the raised position and owner/clinical nurse supervisor/licensed assisted living director (O/CNS/LALD)-A stated staff had just lowered the rails. O/CNS/LALD-A stated R4 was able to transfer independently and did not utilize the bed rails. R4's diagnosis included chronic obstructive pulmonary disease (COPD) (progressive	02310			

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02310	Continued From page 84 breathlessness and cough). R4's record included an undated, first page of a Service Plan but lacked the second page. The Service Plan indicated R4 received services including medication administration, housekeeping, laundry, bathing, grooming, dressing and continence assistance. R4's assessment dated January 1, 2024, did not include measurements of the bed rail zones of entrapment or documentation of education on the risk vs benefits of bed rail use. R3 R3's diagnoses included hypertension. R3's record lacked a Service Plan. R3's assessment dated January 1, 2024, did not include measurements of the bed rail zones of entrapment or documentation of education on the risk vs benefits of bed rail use. On August 6, 2024, at 7:39 a.m. O/CNS/LALD-A stated all three residents had hospital beds with bilateral bed rails and she had assessed the bed rails on January 1, 2024; however, the assessments did not include the measurements or education on the risk vs. benefits of bed rail use as she was not aware of the requirement. The Food and Drug Administration's (FDA) A Guide to Bed Safety Bed Rails in Hospitals Nursing Homes and Home Health Care dated June 21, 2006, indicated the following information: "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must	02310			

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02310	Continued From page 85 be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) last updated April 3, 2024, indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, "Documentation about a resident's bed rails includes, but is not limited to: - Purpose and intention of the bed rail; - Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail; - The resident's bed rail use/need assessment; - Risk vs. benefits discussion (individualized to each resident's risks); - The resident's preferences; - Installation and use according to manufacturer's guidelines; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements". Additionally, the MDH website indicated for hospital-style bed rails, the licensee must include	02310			

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02310	Continued From page 86 in their documentation, the bed rail measurements and that the bed rail has not shifted and is securely attached to the bed frame per manufacturer recommendations. No further information was provided. The licensee's undated, Use of Side Rails policy noted an assessment would determine whether the equipment meets the FDA standards for side rails. The registered nurse (RN) would document the teaching provided regarding the risk of using side rails. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate The immediacy was lifted on August 6, 2024; however, non-compliance remains at level 3/Widespread (I). Oxygen Cylinders Based on observation, interview, and record review, the licensee failed to ensure oxygen cylinders were secured in a rack to prevent tipping or damage for one of one resident (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: On August 6, 2024, at 2:35 p.m. the surveyor	02310			

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02310	Continued From page 87 observed three portable oxygen cylinders sitting on the floor alongside the wall, unsecured. At this time, O/CNS/LALD-A stated the oxygen cylinders were unsecured and indicated they could be easily tipped over. O/CNS/LALD-A further stated she did not have an oxygen rack or chains to secure the cylinders and would need to ask the oxygen company for something to prevent them from falling over. The Minnesota Department of Health Oxygen Cylinder Storage Requirements dated April 16, 2020, indicated cylinders must be secured (chains or racks) to prevent them from falling over. The licensee's undated, Safe Oxygen Use and Storage policy noted the facility staff will ensure that the resident has an appropriate storage cart or stand for the oxygen cylinder and will educate the resident/resident's representative about safe use and storage of oxygen. No additional information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	02310			
02320 SS=D	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan.	02320			

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02320	Continued From page 88 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure delegated procedures were followed for one of one resident (R2) observed during medication administration. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2's diagnoses included diabetes. R2's Service Plan dated May 6, 2019, indicated R2 received services including medication administration. On August 6, 2024, at 7:25 a.m. unlicensed personnel (ULP)-B was observed setting up medications to administer for R2. R2's oral medications had been set up by the pharmacy in one blister package. The package listed the name and dosage of each medication on the back of the blister package. ULP-B opened the blister package and poured the medications into a medication cup without comparing what was listed on the back of the package with R2's medication administration record (MAR). ULP-B then set-up R2's Novolog FlexPen (fast-acting insulin) pen and dialed the insulin pen to eight units. ULP-B did not compare the labels on the insulin pen with R2's MAR. ULP-B brought the	02320			

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02320	Continued From page 89 medication cup and insulin pen to R2's room. ULP-B provided R2 the oral medications which R2 consumed independently. ULP-B then handed R2 the insulin pen in which R2 administered his own insulin into his abdomen. When interviewed immediately following the observation, ULP-B stated she had not compared R2's medications with the MAR as the data would most likely line up since the medications had come from the pharmacy. ULP-B further stated the registered nurse had trained her to administer medications. On August 6, 2024, at 9:15 a.m. owner/clinical nurse supervisor/licensed assisted living director (O/CNS/LALD)-A stated she conducted the training and competency of staff for medication administration. O/CNS/LALD-A stated she expected staff to compare residents' medication labels with the orders in the MAR when setting up medications for administration. The licensee's undated, Documentation of Medication Administration policy indicated: 2. Staff administering medications will verify the medications are set up correctly before administration to the client by using the medication profile. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320			
03090 SS=C	144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security	03090			

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03090	Continued From page 90 cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure the required notice was posted at the main entry way of the establishment to display statutory language to disclose electronic monitoring activity, potentially affecting all current residents, staff, and any visitors of the facility. This practice resulted in a level one violation (a violation that has not potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The finding include: On August 5, 2024, at approximately 11:45 a.m. upon arriving at the establishment, an observation outside the front entrance, or just inside the front entrance, lacked the required posting for electronic monitoring devices. During the facility tour on August 5, 2024, at 1:03 p.m. the surveyor toured the residence with owner/clinical nurse supervisor/licensed assisted living director (O/CNS/LALD)-A. O/CNS/LALD-A stated the licensee utilized cameras in the common areas of the residence and further stated no posting was available related to the statutory language for electronic monitoring.	03090			

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03090	Continued From page 91 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	03090			

Type: Full
Date: 08/05/24
Time: 11:30:55
Report: 1050241143

Food and Beverage Establishment Inspection Report

Page 1

Location:

Twin Cities Nursing Care
1635 Hazel Street North
St Paul, MN 55119
Ramsey County, 62

Establishment Info:

ID #: 0037823
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6517972115
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.

RESIDENCE DOES NOT HAVE A CURRENT ILLNESS LOG ON SITE. DISCUSSED THE IMPORTANCE OF TRACKING AS WELL AS REPORTING PURPOSES. MDH ILLNESS LOG PROVIDED VIA EMAIL. COMPLY WITH RULE ABOVE.

Comply By: 08/05/24

4-700 Sanitizing Equipment and Utensils

4-702.11

**** Priority 1 ****

MN Rule 4626.0900 Sanitize utensils and food contact surfaces of equipment before use, after cleaning. FACILITY IS WASHING DISHES WITH SOAP AND WATER IN ONE BASIN OF THE TWO BASIN SINK, NO SANITIZE STEP. INSTRUCTED ESTABLISHMENT TO SET UP CONTAINERS TO WASH, RINSE, SANITIZE DISHES WITH 50-100 PPM BLEACH UNTIL UNDER COUNTER DISH MACHINE OR 3 COMP.

Comply By: 08/05/24

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment. FACILITY DOES NOT HAVE A CFPM CERTIFICATE ON SITE DURING INSPECTION. DISCUSSED WITH OWNER SHE STATED SHE HAS ONE BUT CANNOT FIND IT. WHEN FOUND PLEASE POST. COMPLY WITH RULE ABOVE.

Type: Full
Date: 08/05/24
Time: 11:30:55
Report: 1050241143
Twin Cities Nursing Care

Food and Beverage Establishment Inspection Report

Comply By: 08/09/24

Food and Equipment Temperatures

Process/Item: Cold Holding/ Hot Dog
Temperature: 39F Degrees Fahrenheit - Location: Reach-In Cooler
Violation Issued: No

Process/Item: Cold Holding. Cheese
Temperature: 39F Degrees Fahrenheit - Location: Reach-In Cooler
Violation Issued: No

Process/Item: Upright Freezer/ Chicken
Temperature: -2F Degrees Fahrenheit - Location: Freezer
Violation Issued: No

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

Announced inspection completed by MDH Andrew Spaulding and owner Maixia Vang. Susan Kalis was the lead Health Regulation Division Nurse Evaluator. Facility had three residents on site at time of inspection. Meals are prepared only site with leftovers kept for 2-3 days.

This establishment has a residential kitchen. Food must be prepared for same day service only. The kitchen has wood cabinets with a hollow base, vinyl countertops and hardwood floors. All found to be in working condition. Residence does not have a dishwasher advised owner to simulate a 3 compartment sink by adding a basin to use for sanitizing.

- Discussed the following:
- Employee illness policy and logging requirements
 - Hand Washing
 - Glove-use and bare hand contact
 - Food storage and preventing cross contamination
 - Thin Probe thermometer

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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 1050241143 of 08/05/24.

Certified Food Protection Manager: _____

Certification Number: _____ Expires: ____ / ____ / ____

Inspection report reviewed with person in charge and emailed.

Signed: _____

Maixia Vang
Owner

Signed: _____


Andrew Spaulding
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