



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

April 3, 2024

Licensee
Global Case Management
5231 Buchanan Street Northeast
Fridley, MN 55421

RE: Project Number(s) SL33614015

Dear Licensee:

On February 16, 2024, the Minnesota Department of Health (MDH) completed a follow-up survey of your agency to determine correction of orders found on the survey completed on December 13, 2023. The follow-up survey determined your agency had not corrected all of the state licensing orders issued pursuant to the December 13, 2024 survey.

In accordance with Minn. Stat. § 144A.474, Subd. 11, state licensing orders issued pursuant to the last survey, completed on December 13, 2023, found not corrected at the time of the February 16, 2024, follow-up survey and/or subject to penalty assessment are as follows:

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

The details of the violations noted at the time of this follow-up survey completed on February 16, 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.

The total amount you are assessed is \$500.00. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

In accordance with Minn. Stat. § 144A.474, Subd. 8(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.

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 § 144A.475 for widespread violations;

Level 3: a fine of \$3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144A.475.

Level 4: a fine of \$5,000 per incident, in addition to any enforcement mechanism authorized in § 144A.475.

CORRECTION ORDER RECONSIDERATION PROCESS

In accordance with Minn. Stat. § 144A.474, Subd. 12, you may challenge the correction order issued, including the level and scope, and any fine assessed through the correction order reconsideration process.

The request for reconsideration must be in writing and received by the Department of Health within 15 business days of the correction order receipt date.

A state licensing order under Minn. Stat. § 144A.44 Subd. 1(14), 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>

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144A.474, Subd. 11 (g), a home care 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. § 144A.475, subd 4 and Subd. 7, a request for a hearing must be in writing and received by MDH within 15 calendar days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. To submit a hearing request, please visit

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

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

We urge you to review these orders carefully. If you have questions, please contact Bob Dehler at 651-201-3710.

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, appearing to read "Robert Dehler", with a long horizontal line extending to the right.

Bob Dehler, P.E.
Engineering Manager
Engineering Services Section
Health Regulation Division
Email: Robert.Dehler@state.mn.us
Telephone: 651-201-3710

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33614	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 02/16/2024
NAME OF PROVIDER OR SUPPLIER GLOBAL CASE MANAGMENT		STREET ADDRESS, CITY, STATE, ZIP CODE 5231 BUCHANAN STREET NE FRIDLEY, MN 55421			
(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: SL33614015-1 On on February 15, 2024, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on December 13, 2024. At the time of the survey, there were three residents; Three receiving services under the Assisted Living license. As a result of the revisit, 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 License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.		
{0 460} SS=F	144G.41 Subdivision 1 Minimum requirements (5) provide a means for residents to request assistance for health and safety needs 24 hours	{0 460}			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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{0 460}	Continued From page 1 per day, seven days per week; (6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract; (7) permit residents access to food at any time; (8) allow residents to choose the resident's visitors and times of visits; (9) allow the resident the right to choose a roommate if sharing a unit; (10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living facility must not lock a resident in the resident's unit; This MN Requirement is not met as evidenced by: No further action needed.	{0 460}			
{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 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;	{0 470}			

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{0 470}	Continued From page 2 (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: No further action needed.	{0 470}			
{0 480} SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: No further action needed.	{0 480}			
{0 510} SS=F	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	{0 510}			

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{0 510}	Continued From page 3 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: No further action needed.	{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 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: No further action needed.	{0 550}			

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{0 640}	Continued From page 4	{0 640}			
{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 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: No further action needed.	{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	{0 650}			

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{0 650}	Continued From page 5 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: No further action needed.	{0 650}			
{0 660} SS=D	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: No further action needed.	{0 660}			
{0 680} SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness	{0 680}			

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{0 680}	Continued From page 6 (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: No further action needed.	{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	{0 780}			

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{0 780}	Continued From page 7 the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that are interconnected so the actuation of one alarm causes all alarms in the dwelling unit to actuate. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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).	{0 780}			

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{0 780}	Continued From page 8 The findings include: During the facility tour on February 15, 2024, at 12:00 p.m., with licensed assisted living director (LALD)-C, it was observed upon testing the smoke alarms in resident sleeping rooms #1, #2, #3 on the main level and sleeping room #5 on the lower level were not interconnected, so the actuation of one smoke alarm would cause all other alarms in the facility to actuate. On January 8, 2024, at 1:00 p.m., LALD-C confirmed the licensee installed smoke alarms in the resident's sleeping rooms, but the smoke alarms were not interconnected to each other.	{0 780}			
{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."	{0 950}			

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{0 950}	Continued From page 9 (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: No further action needed.	{0 950}			
{01290} SS=F	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: No further action needed.	{01290}			
{01380} SS=D	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn	{01380}			

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{01380}	Continued From page 10 (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: No further action needed.	{01380}			
{01470} SS=E	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff	{01470}			

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{01470}	Continued From page 11 responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated 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	{01470}			

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER GLOBAL CASE MANAGMENT		STREET ADDRESS, CITY, STATE, ZIP CODE 5231 BUCHANAN STREET NE FRIDLEY, MN 55421			
(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	
{01470}	Continued From page 12 access in real time, and closed captions. This MN Requirement is not met as evidenced by: No further action needed.	{01470}			
{01500} SS=D	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 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	{01500}			

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{01500}	Continued From page 13 (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: No further action needed.	{01500}			
{01760} SS=F	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of	{01760}			

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{01760}	Continued From page 14 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: No further action needed.	{01760}			
{01820} SS=D	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: No further action needed.	{01820}			
{01880} SS=D	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: No further action needed.	{01880}			
{01890} SS=D	144G.71 Subd. 20 Prescription drugs	{01890}			

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{01890}	Continued From page 15 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: No further action needed.	{01890}			
{02290} SS=F	144G.91 Subd. 2 Legislative intent The rights established under this section for the benefit of residents do not limit any other rights available under law. No facility may request or require that any resident waive any of these rights at any time for any reason, including as a condition of admission to the facility. This MN Requirement is not met as evidenced by: No further action needed.	{02290}			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

January 8, 2024

Licensee
Global Case Management
5231 Buchanan Street Northeast
Fridley, MN 55421

RE: Project Number(s) SL33614015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on December 13, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

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), the MDH may impose fine amounts of either \$1,000 or \$5,000 to licensees who are found to be responsible for maltreatment. The 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. The 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.

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

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program = \$500.00

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

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$3,500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

<https://forms.web.health.state.mn.us/form/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 state form with your organization's Governing Body.

If you have any questions, please contact me.

Sincerely,

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

Casey DeVries, Supervisor

State Evaluation Team

Email: casey.devries@state.mn.us

Telephone: 651-201-5917 Fax: 1-866-890-9290

PMB

Minnesota Department of Health

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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: SL33614015-0 On December 11, 2023, through December 13, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were three residents, all of whom received services under the Assisted Living license. An immediate correction order was identified on December 12, 2023, issued for SL33614015-0, tag identification 0820. On December 12, 2023, the immediacy of correction order 0820 was removed, however non-compliance remained, and the scope and level remained unchanged.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.		
0 460 SS=F	144G.41 Subdivision 1 Minimum requirements	0 460			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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0 460	Continued From page 1 (5) provide a means for residents to request assistance for health and safety needs 24 hours per day, seven days per week; (6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract; (7) permit residents access to food at any time; (8) allow residents to choose the resident's visitors and times of visits; (9) allow the resident the right to choose a roommate if sharing a unit; (10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living facility must not lock a resident in the resident's unit; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide a means for residents to request assistance for health and safety needs 24 hours a day, seven days a week. 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:	0 460			

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0 460	Continued From page 2 On December 11, 2023, at 10:10 a.m., during the entrance conference, licensed assisted living director (LALD)-D stated they did not have a call light or pendant system residents could use to summon staff. LALD-D stated two of their three residents had cell phones they could use. LALD-D stated residents were checked on frequently and could yell or scream if they required assistance. On December 11, 2023, at 11:05 a.m., during the entrance tour, the surveyor observed the facility was a rambler style home with a main floor and basement. One resident's room was in the basement while the other two residents were on the main floor. No pendants or call light system were observed during the facility tour. On December 13, 2023, at 12:00 p.m., LALD-D stated they did not have call light or pendant system and didn't feel they were needed as the residents at the facility were very independent. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 460			
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 3 on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure their required staffing plan was reviewed two times per year. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's Facility Staffing Plan, undated and prepared by clinical nurse supervisor (CNS)-A,	0 470			

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0 470	Continued From page 4 indicated staffing requirements for each shift as follows: -Monday through Friday, one direct care staff required for the morning, evening, and overnight shift; and -Saturday through Sunday, one direct care staff required for the morning, evening, and overnight shift. On December 11, 2023, at 10:10 a.m., during the entrance conference, licensed assisted living director (LALD)-D stated the staffing plan was last updated on April 1, 2023. On December 13, 2023, at 3:04 p.m., LALD-D stated they were aware their staffing plan was required to be updated two times per year but was not completed. The licensee's Facility Staffing Plan, undated, indicated: "The staffing plan considered the following requirements: -Individual resident needs and acuity level based on the assessment, Service Plan and Assisted living contract -Staff ability to respond promptly to scheduled and unscheduled needs of residents and considering the physical layout of the facility -Education, competence and experience of scheduled staff -Requirements related to missing resident policy -Requirements related to emergency preparedness plan" No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470			

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0 480	Continued From page 5	0 480			
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to adhere to the Minnesota Food Code, Minnesota Rules, chapter 4626. This had the potential to affect all residents at 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, 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: Please refer to the additional documentation included in the Food and Beverage Establishment Inspection Report (FBEIR) dated December 11, 2023. 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			

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0 510	Continued From page 6	0 510			
0 510 SS=F	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 that complies with accepted health care, medical and nursing standards for infection control. The deficient practice had the potential to affect residents, employees, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On December 11, 2023, at 1:03 p.m., the surveyor observed unlicensed personnel (ULP)-B	0 510			

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0 510	Continued From page 7 check R1's blood glucose (BG) and administer insulin. R1's medication drawer included a red Complete Needle Collection sharps container (puncture resistant and spill proof container used for disposal of used needles), approximately 4x4x10 inches in size. The sharps container label indicated, "BIOHAZARD DO NOT OVERFILL," and "SINGLE USE ONLY." The sharps container had an arrow pointing to a dotted line approximately two-thirds of the way from the bottom of the container and indicated, "FILL LINE DO NOT OVERFILL." The sharps container's spill resistant lid had been broken off, but a portion of the lid remained leaving sharps items exposed. The sharps container was completely filled to the rim with used insulin FlexPen needles and lancets (a needled skin puncturing device for BG testing), beyond the dotted line. ULP-B pushed R1's used lancet into the sharps container using their right pointer finger exposing themselves to used needles. R1 disposed of a used FlexPen needle in the sharps container by balancing it on the top of the container. On December 11, 2023, at 1:15 p.m., ULP-B stated the sharps container was too full and needed to be emptied. They stated it was only used for R1. ULP-B stated the sharps container should be emptied and reused. On December 12, 2023, at 11:33 a.m., the surveyor observed the facility medication cart with clinical nurse supervisor (CNS)-A. The sharps container in R1's drawer was the same broken sharps container observed on December 11, 2023, but had been emptied. The surveyor explained the sharps container in R1's drawer was the same broken sharps container used by ULP-B on the day prior, which was full at the time. CNS-A acknowledged the sharps container's spill	0 510			

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0 510	Continued From page 8 proof lid had been broken off. CNS-A stated staff were instructed to stop using a sharps container when it was half full. CNS-A stated a sharps container should never be reused and broken sharps containers should be discarded. CNS-A stated licensed assisted living director (LALD)-D disposed of full sharps containers. The surveyor questioned who emptied the sharps container and where, CNS-A stated they did not know who or where it was emptied but was likely emptied into their other sharps container hanging on the wall. The surveyor observed a locked wall hanging SharpSafety with a safety lid rolling mechanism approximately 4x12x9 inches in size, a red OakRidge sharps container was inside of the lock box. The wall hanging sharps container was located in the staff office behind a locked door. The safety rolling mechanism had a used purple and white lancet stuck on top of the roller. The lancet was positioned in a way where it could be rolled onto the top of the operator's hand potentially poking them. CNS-A acknowledged the lancet created a risk for the user and would get it removed from the safety rolling mechanism. CNS-A did not remove the broken sharps container from R1's medication drawer. On December 12, 2023, at 11:59 a.m., the surveyor observed ULP-B check R1's BG. ULP-B was going to use the broken sharps container which remained in R1's drawer. The surveyor intervened and stopped ULP-B from using the broken sharps container due to safety concerns. CNS-A called from the other room telling ULP-B not to use the broken container and to instead use the one on the wall. The earlier mentioned lancet remained stuck on the safety rolling mechanism for the sharps container on the wall. The surveyor explained to ULP-B there was a used lancet in the safety rolling mechanism,	0 510			

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0 510	Continued From page 9 ULP-B was observed carefully disposing of the used lancet they had just used. On December 12, 2023, at 12:18 p.m., the surveyor observed R1's medication drawer with CNS-A, the broken sharps container remained in R1's medication drawer. The surveyor told CNS-A to remove the broken sharps container from the drawer so it could not be used by staff. The surveyor observed CNS-A remove the sharps container from R1's medication drawer. On December 12, 2023, at 3:04 p.m., LALD-D and CNS-A stated a new sharps container should have been used once it was half-full or when it was identified as being broken. LALD-D showed the surveyor their storage cabinet which had new unused sharps containers, they stated they did not know why staff did not use a new one. LALD-D and CNS-A both stated they did not know who had emptied the broken sharps container. They stated the sharps containers were disposed of at the pharmacy. The Center for Disease Control (CDC) website last reviewed on February 26, 2019, indicated: "Sharps Injuries: Sharps Disposal -Improper sharps disposal is another significant cause of sharps injury in the workplace. Injuries related to improper sharps disposal can occur for the following reasons: -Inappropriate sharps disposal practices by the worker, such as insufficient maintenance of sharps containers in every area. Designated staff should monitor the fill level of all containers, prohibit placement of nonsharps waste in a sharps container, and ensure that all staff are educated in proper sharps disposal. -Improper design of sharps disposal container. -Improper selection of sharps containers for the	0 510			

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0 510	Continued From page 10 procedures being performed (e.g., surgical instruments) -Overfilling sharps disposal container. Guidelines: Sharps disposal containers NIOSH used focus groups to determine the critical elements needed for secure and safe sharps disposal containers. The results of these studies suggest the importance of four criteria: functionality, accessibility, visibility, and accommodation. 1. Functionality: Containers should be puncture-resistant, durable during installation and transport, and an appropriate size and shape. The closure should be secure and minimize exposure during closure. 2. Accessibility: Containers should be upright and easy to operate while preventing the contents from spilling. The container should be placed in a visible location, within easy horizontal reach, and below eye level. The container should also be placed away from any obstructed areas, such as near doors, under sinks, near light switches, etc. 3. Visibility: Containers should be clearly visible to the health care worker. The container should be designed so that workers may be able to easily determine the container's fill status and distinguish any warning labels. 4. Accommodation: Containers should facilitate ease of storage and assembly, require minimal worker training requirements, be easy to operate, and have a flexible design. A container should also easily accommodate one-handed disposal of a sharps device. Product design should minimize sharp surfaces and cross-infection hazards. Installation and mounting systems should be safe, durable, stable, and cleanable." The CDC posted research document National Institute for Occupational Safety and Health Selecting, Evaluating, and Using Sharps Disposal	0 510			

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0 510	Continued From page 11 Containers research document dated January 1998, page six, indicated: "An individual or a group should be assigned the responsibility for regular monitoring and maintenance of sharps disposal containers. The designee(s) should frequently and routinely monitor fill levels of containers and be responsible for changing containers before they are overfilled. Each time a reusable sharps disposal container is returned to service after reprocessing, the user facility should confirm that it meets its original performance elements. In addition, reusable sharps disposal containers should be rendered free of infectious organisms and infectious material each time they are reprocessed and before they are returned to service." The licensee's Infection Control policy dated May 26, 2020, indicated, "All sharp instruments and needles are discarded in a puncture-resistant container. The CDC recommends needles be disposed of without capping or that a mechanical device be used for recapping." No further information provided. TIME PERIOD FOR CORRECTION: Two (2) 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	0 550			

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0 550	Continued From page 12 information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post the required information related to the grievance procedure. This had the potential to affect all three residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a 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 December 11, 2023, at 11:05 a.m., during the facility tour, the surveyor observed the licensee's Grievance Procedure, undated, posted on a bulletin board in the commons area which lacked the following required information: - if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints (OHFC) at the Minnesota Department of Health.	0 550			

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0 550	Continued From page 13 On December 11, 2023, at 11:05 a.m., licensed assisted living director (LALD-D) acknowledged the posting lacked the above content. LALD-D stated they thought the OHFC information was included in the grievance policy. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550			
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 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 post the 911 emergency number in common areas and near telephones provided by the assisted living facility. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	0 640			

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0 640	Continued From page 14 resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On December 11, 2023, at 11:55 a.m., the surveyor observed one black wireless landline phone on a coffee table, in the living room area, which lacked the required posting of the 911 emergency number. On December 11, 2023, at 11:55 a.m., unlicensed personal (ULP)-B stated the phone was used by residents and staff. On December 12, 2023, at 12:38 p.m., licensed assisted living director (LALD-D) acknowledged the telephone lacked the required posting of 911 emergency number. LALD-D stated the licensee was not aware of the requirement and would post 911 emergency number by phone. 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,	0 650			

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0 650	Continued From page 15 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 three employees (unlicensed personnel (ULP)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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 was hired on November 15, 2018, to provide direct care to residents.	0 650			

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0 650	Continued From page 16 On December 11-12, 2023, the surveyor observed ULP-B cooking and administering resident medication. ULP-B's employee training record lacked the following required content: - reports of changes in the resident's condition to the supervisor designated by the assisted living provider; - the ULP has been trained and has demonstrated competency to the RN on how to administer medication on all routes. On December 12, 2023, at 10:18 a.m., ULP-B stated they received education on how to report changes in resident condition. On December 12, 2023, at 1:50 p.m., ULP-B stated they received medication administration training on Educare (online training platform), practiced how to administer medication on all routes, and demonstrated back to the nurse. On December 12, 2023, at 10:28 a.m., clinical nurse supervisor (CNS)-A stated the ULP-B received online education on Educare first, then they did practical trainings and were deemed competent after they demonstrated skills back to CNS-A. CNS-A stated documentation was in the employee record but was unable to find it in the record. The licensee's Personnel Records policy dated May 26, 2020, read, "1. A personnel record will be started for each staff member upon hire. 2. At a minimum, all documents related to the following are kept in the personnel record, as applicable to job requirements:	0 650			

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0 650	Continued From page 17 - Evidence of current professional licensure, registration or certification - Results of background studies - Records of annual training and infection control training - Documentation of orientation - Documentation of supervision, as applicable - Performance reviews - Competency evaluations - Signed job description - Documentation of annual performance reviews identifying 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=D	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.	0 660			

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0 660	Continued From page 18 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), which included a two-step tuberculin skin test (TST) or other evidence of TB screening such as a blood test, and a completed health history and symptom screening for one of three employees (clinical nurse supervisor (CNS)-A). 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: CNS-A was hired on June 27, 2022, to provide nursing care to residents and to provide oversite to unlicensed personnel. On December 12-13, 2023, the surveyor observed CNS-A in the licensee's facility working with surveyors, interacting with residents, and providing oversight to unlicensed personnel (ULP). CNS-A's employee record included step-one TST completed on May 12, 2022, however lacked a second step TST. CNS-A's employee record also included an incomplete symptom screening form dated June 27, 2022.	0 660			

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0 660	Continued From page 19 On December 12, 2023, at 10:28 a.m., CNS-A reviewed the symptom screening form and acknowledged it was not complete. CNS-A stated they were responsible for making sure the form was complete. CNS-A stated they might have another completed form in the file but was unable to find it. On December 12, 2023, at 11:30 a.m., CNS-A stated they completed a two-step TST at their other job and gave the results to the licensed assisted living director (LALD-D) upon hire. On December 12, 2023, at 3:30 p.m., LALD-D provided CNS-A's two-step TST dated May 10, 2022, which lacked the second step of the test. LALD-D stated they would email the surveyor the second step of the TST. On December 12, 2023, at 6:47 p.m., LALD-D emailed another copy of the above mentioned first step TST result but did not include the second TST result. The CDC Tuberculosis Screening, Testing, and Treatment of U.S. Health Care Personnel dated May 17, 2019, indicated all health personnel should have a baseline screening and an individual risk assessment, which is necessary for interpreting any test result. The licensee's Tuberculosis Screening/Prevention policy dated May 26, 2020, read, "Policy Statement: Global Case Management will observe the recommended precautions related to TB prevention as identified by the Centers for Disease Control and Prevention (CDC) and the	0 660			

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0 660	Continued From page 20 Minnesota Department of Health (MDH). The precautions include the following elements. Risk Assessment TB Screening Staff Education Baseline TB Testing: Baseline TB screening at the time of hire is required for all HCWs in Minnesota. Baseline TB screening consists of three components: (1) assessing for current symptoms of active TB disease, and (2) assessing TB history and 3) TB testing for the presence of infection with Mycobacterium tuberculosis by administering either a two- step TST or single TB blood test." 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; (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	0 680			

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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
0 680	Continued From page 21 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 the emergency preparedness plan (EPP) prominently. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On December 11, 2023, at 11:05 a.m., during the facility tour, the surveyor observed the common areas shared by residents, staff, and visitors lacked the required posting of the EPP in a prominent area. On December 11, 2023, at 11:05 a.m., licensed assisted living director (LALD)-D stated the EPP binder was kept locked in the office and verified there was no posting to direct staff, residents, and visitors as to where to find the EPP binder. LALD-D also stated they did not know the posting	0 680			

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0 680	Continued From page 22 of the EPP in prominent area was a requirement. The licensee's Emergency Preparedness policy dated May 26, 2020, read, "12. The Emergency Disaster Plan is posted at each residence. 13. The Evacuation Plan is posted on each floor of each residence and a copy is provided to all residents on admission." 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: (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	0 780			

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0 780	Continued From page 23 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 are interconnected so the actuation of one alarm causes all alarms in the dwelling unit to actuate. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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 facility tour on December 12, 2023, at 11:00 a.m., with licensed assisted living director (LALD)-D, it was observed the installed smoke alarm in the living room in the basement was interconnected to multiple smoke alarms in the main level only but was not interconnected to resident sleeping rooms in the basement. It was also observed the resident sleeping rooms on the main level, which were equipped with smoke alarms, were not interconnected with the immediate outside of the resident sleeping room alarms. During the interview on December 12, 2023, at	0 780			

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0 780	Continued From page 24 11:00 a.m., LALD-D stated the smoke alarms came in packages of 4, so it was possible they were not all linked together for that reason. LALD-D verified the smoke alarms in the facility were not interconnected. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780			
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the 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 and staff. 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).	0 800			

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0 800	Continued From page 25 The findings include: On December 12, 2023, at 11:00 a.m., survey staff toured the facility with licensed assisted living director (LALD)-D. During the facility tour, it was observed outside the exit door, used cigarettes were disposed of without a proper disposal container, creating a possible fire hazard. The provided smoking ashtray was a metal container without cover and was sitting on a plastic patio furniture table. On December 12, 2023, at 11:00 a.m., LALD-D verified no fire-safe disposal container was provided for smoking residents. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800			
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) 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	0 810			

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0 810	Continued From page 26 thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on the interview and record review, the licensee failed to develop a fire safety and evacuation plan with the required elements and failed to provide required employee training on fire safety and evacuation as required. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On December 12, 2023, at 1:00 p.m., licensed	0 810			

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0 810	Continued From page 27 assisted living director (LALD)-D provided documentation on the fire safety and evacuation plan (FSEP), fire safety and evacuation training for the facility, and fire safety and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The fire safety and evacuation plan was a third-party consultant provided plan, and it was not updated to meet the facility-specific layout. The fire safety and evacuation plan included the RACE (Remove, Alarm, Confine and Extinguish or Evacuate) acronym as the fire safety procedure and instructed staff to pull the nearest fire alarm in case of fire, but the facility did not have a fire alarm system. The FSEP included standard employee actions to be taken but failed to provide specific procedures for employees to evacuate residents based on the facility's specific layout in the event of a fire or similar emergency. During the interview on December 12, 2023, at 1:00 p.m., LALD-D stated the policy was from a third-party provider and had yet to be edited or updated to fit the facility and verified that the fire safety and evacuation plan for the facility lacked these provisions. TRAINING Record review of the available documentation indicated employees did not receive training twice per year after initial hire.	0 810			

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0 810	Continued From page 28 During the interview on December 12, 2023, at 1:00 p.m., LALD-D stated the licensee provided annual training on the fire safety and evacuation plan to employees, but not twice per year after the initial hire, as required by statute. LALD-D confirmed that there was no further documented training for the staff on the fire safety and evacuation plan as required by statute. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810			
0 820 SS=G	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 correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure physical facility elements did not constitute a distinct hazard to life. The licensee failed to provide a resident bedroom with the minimum window opening meeting the minimum state standard for egress. This affected the occupied resident in bedroom #3 on the main	0 820	This immediate correction order identified on December 12, 2023, had the immediacy removed on December 12, 2023, however non-compliance remained at an scope and level of I. This was confirmed by the licensee via		

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0 820	Continued From page 29 level. 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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On December 12, 2023, at 10:00 a.m., survey staff toured the facility with the Licensed Assisted Living Director (LALD)-D. During the facility tour, survey staff observed the following items: It was observed that occupied resident bedroom #3 on the main level did not have windows that met the minimum size requirements for egress escape. The clear openable area of the opened windows measured 14 inches in height and 32 inches in width, with a total openable area of 448 square inches. The windows did not meet the minimum requirements for opening height and did not meet the minimum requirements for total openable area. Egress windows in existing sleeping rooms must have a minimum openable width of 20 inches and minimum openable height of 20 inches with no less than 648 square inches total of openable area (4.5 square feet) for the window. Survey staff explained to LALD-D that at least one egress window in each bedroom must be provided to meet the minimum state standard for an egress window to be a complying bedroom for resident occupancy. LALD-D verbally confirmed the	0 820	email and approved by evaluation supervisor.		

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0 820	Continued From page 30 findings. On December 12, 2023, at 11:00 a.m., during the phone interview, survey staff explained to LALD-D that an immediate correction order was issued for the above finding. LALD-D acknowledged the above finding. No Further information was provided. 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	0 950			

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0 950	Continued From page 31 designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to include required verbatim language giving residents the right to identify a designated representative on its own separate page for one of one resident (R1). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: R1 was admitted to the licensee on October 30, 2018. R1's Assisted Living Service Plan dated July 1, 2023, indicated R1 received services for meal preparation, medication management, and mental health management. R1's Resident Contract for Assisted Living signed July 1, 2023, page one included an option to select or decline naming a designated representative. Page two, subsection 1, Parties To Agreement, which lacked customization with the licensee ' s name, indicated, " This Resident Agreement (the "Agreement") is a contract	0 950			

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0 950	Continued From page 32 between the Resident(s) named on the first page of the Agreement and [Legal Name of AL Licensee]. Throughout this Agreement, the terms "we" and "our" refer to [Name of Licensee} and the terms "you", "your" and "Resident" refer to the Resident(s) and the Designated Representative if one is named. 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. If Resident has a legally appointed guardian or conservator or any other legally appointed representative ("Legal Representative"), Resident shall provide Management with a copy of any legal papers designating such a relationship prior to execution of this Agreement, and the guardian, conservator or other legally appointed representative shall execute this Agreement on behalf of the Resident." The licensee's blank contract, undated, included the same statements and organization. On December 12, 2023, at 9:29 a.m., licensed assisted living director (LALD)-D acknowledged R1's contract, and their blank contract, lacked required designated representative verbatim language and were not on their own page separate from the contract and was mixed in with additional contract statements and information. They stated all of their residents had signed identical contracts with the same information. No further information was provided.	0 950			

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0 950	Continued From page 33	0 950			
01290 SS=F	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a background study was submitted and received in affiliation with the assisted living licensee for five of six employees (unlicensed personnel (ULP)-B, ULP-E, ULP-F, ULP-G and clinical nurse supervisor (CNS)-A). 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	01290			

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01290	Continued From page 34 or has the potential to affect a large portion or all of the residents). The findings include: CNS-A CNS-A was hired on June 27, 2022, to provide supervision and oversite to unlicensed personnel and to provide direct services to residents. On December 12-13, 2023, the surveyor observed CNS-A in the licensee's facility working with surveyors, interacting with residents, and providing oversight to unlicensed personnel (ULP). CNS-A was licensed as a registered nurse by the Minnesota Board of Nursing on November 22, 2011. CNS-A's employee record contained a background study dated June 30, 2022, affiliated to licensee's sister facility under Health facility identification (HFID) 33231. CNS-A's record lacked evidence the licensee submitted a background study under the current assisted living license and affiliated to the current HFID number. ULP-B ULP-B was hired on November 15, 2018, to provide direct care to residents. On December 11-12, the surveyor observed ULP-B cooking and administering resident medications. ULP-B's employee record contained a background study dated November 16, 2018, affiliated to licensee's sister facility HFID	01290			

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01290	Continued From page 35 1092410. ULP-B's record lacked evidence the licensee submitted a background study under the current assisted living license and affiliated to the current HFID number. ULP-E ULP-E was hired on August 30, 2023, to provide direct care to residents. ULP-E's employee record contained a background study dated September 11, 2023, affiliated to licensee's sister facility HFID 33231. ULP-E's record lacked evidence the licensee submitted a background study under the current assisted living license and affiliated to the current HFID number. ULP-F ULP-F was hired on May 20, 2018, to provide direct care to residents. ULP-F's employee record contained a background study dated May 24, 2018, affiliated to licensee's sister facility HFID 33231. ULP-F's record lacked evidence the licensee submitted a background study under the current assisted living license and affiliated to the current HFID number. ULP-G ULP-G was hired on September 2, 2021, to provide direct care to residents. ULP-G's employee record contained a background study dated May 1, 2023, affiliated to licensee's sister facility HFID 33231. ULP-G's record lacked evidence the licensee submitted a background study under the current assisted living license and affiliated to the current HFID number.	01290			

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01290	Continued From page 36 On December 12, 2023, at 9:40 a.m., licensed assisted living director (LALD)-D, the licensee's sensitive information person (SIP), was able to demonstrate to the surveyor the 33231 and 1092410 licenses were active and accessible in NETStudy2.0 (web-based system used to submit background study requests to the Department of Human Services), the employees showed as eligible. On December 12, 2023, at 12:38 p.m., LALD-D stated they were not aware background studies had to be affiliated with the licensee's HFID. The licensee's Personnel Records policy dated May 26, 2020, read, "1. A personnel record will be started for each staff member upon hire. 2. At a minimum, all documents related to the following are kept in the personnel record, as applicable to job requirements: Evidence of current professional licensure, registration or certification Results of background studies Records of annual training and infection control training Documentation of orientation Documentation of supervision, as applicable Performance reviews Competency evaluations Signed job description Documentation of annual performance reviews identifying areas of improvement needed and training needs." No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290			

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01380 SS=D	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training was completed in all required areas for one of two employees (unlicensed personnel (ULP)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-B was hired on November 15, 2018, to	01380			

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01380	Continued From page 38 provide direct care to residents. On December 11-12, 2023, the surveyor observed ULP-B cooking and administering resident medications. The licensee's Unlicensed Personnel Competency Evaluation form dated December 3, 2018, indicated the licensee had not provided training to ULP-B and had documented "N/A" for the following topics: - safe transfer techniques and ambulation; and - range of motioning and positioning (ROM). On December 12, 2023, at 10:18 a.m., ULP-B stated they received training on safe transfer techniques with a gait belt and range of motion, but it was not applicable to their residents as their residents were able to ambulate without assistance. On December 12, 2023, at 10:28 a.m., clinical nurse supervisor (CNS)-A reviewed ULP-B's training document and stated ULP-B's training for safe transfer techniques and ROM were not completed. CNS-A stated they were not aware ROM and positioning was a required training, but they were aware safe transfer technique was a required topic. The licensee's Staff Competency policy dated May 26, 2020; read: "4. Home Health Aides (HHA) providing comprehensive home care services and who have not completed a state-approved formal training and competency evaluation program will demonstrate competency through the following process a. Satisfactory completion of an oral or written test on the tasks the HHA will perform. Refer to	01380			

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01380	Continued From page 39 the Competency Manual for criteria. Home Health Aides may not work for Global Case Management until they have successfully passed the written and demonstration competency evaluation. i. Satisfactory completion of the following ii. Observation, reporting and documenting of client status iii. Basic knowledge of body functioning and changes in body function, injuries or other reportable changes iv. Recognizing physical, emotional, cognitive and development needs of the client v. Basic infection control, including blood-borne pathogens vi. Maintenance of a clean and safe environment vii. Falls prevention viii. Safe transfer techniques and ambulation ix. Range of motion and positioning x. Medication, exercise and treatment reminders xi. Basic nutrition, meal preparation, food safety and assistance with eating xii. Preparation of modified diets xiii. Communication skills and barriers xiv. Cultural diversity xv. Confidentiality/privacy xvi. Professional boundaries xvii. Handling of emergencies xviii. Commonly used health technology equipment and assistive devices" No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380			
01470 SS=E	144G.63 Subd. 2 Content of required orientation	01470			

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01470	Continued From page 40 (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must	01470			

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01470	Continued From page 41 include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure staff providing services completed an orientation to assisted living facility licensing requirements and regulations before providing services for two of three employees (clinical nurse supervisor (CNS)-A) and 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 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: CNS-A	01470			

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01470	Continued From page 42 CNS-A was hired on June 27, 2022, to provide nursing care to residents and to provide oversite to unlicensed personnel. On December 12-13, 2023, the surveyor observed CNS-A in the licensee's facility working with surveyors, interacting with residents, and providing oversight to unlicensed personnel (ULP). CNS-A's employee record included training on home care bill of rights completed June 27, 2022, however lacked evidence of orientation to assisted living regulations (144G.63, Sub. 2) effective August 1, 2021, for the following topics: - Overview of Assisted Living statutes; - Assisted Living Bill of Rights; - Handling of resident complaints, reporting of complaints, where to report; - Consumer advocacy services; - Review of types of Assisted Living services the employee will provide and provider's scope of license; and - Principles of person-centered planning/service delivery. ULP-B ULP-B was hired on November 15, 2018, to provide direct care to residents. On December 11-12, 2023, the surveyor observed ULP-B cooking and administering resident medications. ULP-B's employee record included training on home care bill of rights completed November 15, 2018, however lacked evidence of orientation to assisted living regulations (144G.63, Sub. 2) effective August 1, 2021, for the following: - Overview of Assisted Living statutes;	01470			

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01470	Continued From page 43 - Handing 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 December 12, 2023, at 10:18 a.m., ULP-B stated they received education on Educare (online training platform)but were unsure if they received education on the new assisted living regulations and the above-mentioned contents. On December 12, 2023, at 11:30 a.m., CNS-A stated they did a lot of training and orientation paperwork upon hire and gave it to the licensed assisted living director (LALD-D). On December 12, 2023, at 12:38 p.m., LALD-D stated the ULP-B did not receive training on the new assisted living regulations. LALD stated "The rules came down on us all at once." On December 13, 2023, at 12:00 p.m., LALD-D stated the above-mentioned missing trainings for CNS-A were not assigned to the employee due to using the wrong form for orientation. The licensee's Staff Orientation and Education policy dated May 26, 2020, read, "Policy Statement: All staff providing home health care through Global Case Management will be prepared to provide safe, effective services to all clients through a thorough orientation and education program pertinent to the needs of the clientele. Procedure 1. Upon hire and before providing service to clients, all employees attend a general orientation conducted by Global Case Management. Those	01470			

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01470	Continued From page 44 providing direct services will complete a competency evaluation as part of the orientation process.* 2. Orientation is provided by the Director of Nursing or delegate. All clinical topics will be addressed by the RN or other appropriately licensed health care professional. 3. Orientation topics will include, but not be limited to, the following a. Overview of Minnesota Home Care Statute Sections 144A.43 to 144A.4798 b. Review of the employee's job description and responsibilities c. Review of the organization's policies and procedures related to the provision of home care services by the staff member d. Handling of emergencies and the use of emergency services e. Compliance with Minnesota's Vulnerable Adult/Minor Acts (Sections 626.556 and 626.557) and specific requirements per organizational policy, including information on common entry point f. Home Care Bill of Rights g. Grievance Policy/Process h. Consumer advocacy services, including i. Office of Ombudsman for Long-Term-Care ii. Office of Ombudsman for Mental Health iii. Office of Ombudsman for Developmental Disabilities iv. Managed Care Ombudsman at the Department of Human Services v. County managed care advocates vi. Other advocacy services i. Organization's Scope of Services."	01470			

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01470	Continued From page 45 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470			
01500 SS=D	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 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	01500			

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01500	Continued From page 46 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 interview and record review, the licensee failed to ensure an employee received at least eight hours of annual training for each 12 months of employment for one of three employees (clinic nurse supervisor (CNS)-A). 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	01500			

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01500	Continued From page 47 situation has occurred only occasionally). The findings include: CNS-A was hired on June 27, 2022, to provide supervision and oversight to unlicensed personnel and to provide direct services to residents. CNS-A's employee record lacked eight hours of annual training completed within the last 12 months to include: - reporting maltreatment of vulnerable adults; - assisted living bill rights; - infection control; - review of provider policies and procedures; and - principles of person-centered planning/service delivery. On December 12, 2023, at 11:30 a.m., CNS-A stated they did annual training and gave it to licensed assisted living director (LALD)-D. On December 14, 2023, at 12:00 p.m., LALD-D stated the above-mentioned missing trainings for CNS-A were not assigned to the employee due to using the wrong form for training. The licensee's Staff Orientation and Education policy dated May 26, 2020, read, "All staff providing direct home care will complete at least eight (8) hours of education for every twelve (12) months of employment. Education topics will include, but not be limited to, the following a. Reporting of maltreatment of adults or minors b. Review of Home Care Bill of Rights c. Review of the organization's policies and procedures related to implementation of home care services d. Infection control techniques used in the home	01500			

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01500	Continued From page 48 i. Implementation of infection control standards based on current recommendations per the CDC**** ii. Hand washing iii. Need for/use of personal protective equipment (PPE) iv. Appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes and razor blades v. Disinfection of reusable equipment vi. Disinfection of environmental surfaces vii. Reporting of communicable diseases." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500			
01760 SS=F	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	01760			

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01760	Continued From page 49 review, the licensee failed to administer resident medications according to provider orders for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On December 11, 2023, at 10:10 a.m., during the entrance conference licensed assisted living director (LALD)-D stated they used ECP (charting software) on tablets for medication administration and documentation. R1 R1's service plan dated July 1, 2023, indicated R1 received medication management services. R1's prescription dated May 19, 2023, indicated R1 took the following medication: -Novolog FlexPen insulin, 100 units (u)/milliliter (ml), subcutaneous (SQ) Solution Pen-injector (insulin aspart), inject 5u SQ three times daily if blood glucose (BG) is 160 or greater before breakfast or lunch or > (greater than) 125 before dinner, inject 10u SQ if BG >220 and 15u if BG >280. R1's medication administration record (MAR) for December 2023, indicated: - Novolog FlexPen insulin, 100u/ml inj (injection), inject 5u SQ three times a day if BG >160 before breakfast/lunch or >125 before dinner, inject 10u	01760			

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01760	Continued From page 50 SQ if BG >220. Sliding scale: Administer 5u if BG level is over 160. Administer 10u if BG level is over 220. Administer 15u if BG level is over 280. R1's MAR for December 2023, included documentation of the BG readings taken and initials of the staff member who administered the Novolog FlexPen insulin, however it did not identify the number of insulin units administered. It indicated unlicensed personnel (ULP-B) administered R1's insulin on: -December 4, 2023, at 3:26 p.m., BG reading of 128; -December 5, 2023, at 1:09 p.m., BG reading 256; and -December 6, 2023, at 12:05 p.m., BG reading 205. On December 11, 2023, at 11:59 a.m., the surveyor observed R1's medication administration instructions in ECP (charting software for medication administration and documentation) with ULP-B which indicated: "Directions inject 5 units subcutaneously three times a day if blood sugar >160 before breakfast/lunch or >125 before dinner, inject 10 units subcutaneously." "Med Pass Notes Sliding Scale: Administer 5 units if Blood Glucose Level is over 160. Administer 10 units if Blood Glucose level is over 220. Administer 15 units if Blood Glucose is over 280." On December 12, 2023, at 11:59 a.m., the surveyor observed R1's Novolog FlexPen with ULP-B during medication administration which indicated: -Novolog FlexPen 100u/ml inj, inject 5u SQ three times a day if BG >160 before breakfast/lunch or >125 before dinner, inject 10u SQ if BG >220.	01760			

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01760	Continued From page 51 On December 11, 2023, at 1:03 p.m., the surveyor observed R1's lunchtime medication administration conducted by ULP-B. ULP-B used R1's glucometer (device used to measure BG levels) to check R1's BG which was 230. ULP-B obtained R1's Novolog FlexPen from the medication cart, dialed it to 10u and handed it to R1 with a disposable needle to attach to the FlexPen. The surveyor observed ULP-B did not look at R1's ECP MAR, check R1's FlexPen labeling or perform checks and rights of administration. R1 attached the needle to the FlexPen and was about to administer it into his lower left abdomen without priming the FlexPen needle. The surveyor stopped R1 from self-administering the insulin. The surveyor inquired if R1 had primed the FlexPen needle with 2u of insulin, R1 stated they had. The surveyor observed R1's Novolog FlexPen which was still set to 10u and would have been at 8u had R1 primed it. The surveyor inquired why ULP-B had not reviewed R1's Novolog FlexPen insulin orders in ECP prior to administering the medication, ULP-B stated they had looked in ECP in the kitchen before they brought R1 into the room to check their BG. The surveyor had ULP-B show the surveyor the Novolog FlexPen order in ECP. ECP was opened and prompted ULP-B to enter in R1's BG reading before they could proceed to the Novolog FlexPen orders. ULP-B stated ECP required them to enter a BG reading before they could view the full order. The surveyor observed R1's Novolog FlexPen orders in ECP with ULP-B which indicated 10u of insulin should be administered for a BG reading over 220 before lunch. ULP-B then compared R1's Novolog FlexPen pharmacy label with ECP to confirm her medication administration was correct and allowed R1 to self-administer the Novolog	01760			

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01760	Continued From page 52 FlexPen without priming it. ULP-B documented the administration in ECP. On December 11, 2023, at 1:15 p.m., ULP-B stated they were trained by the nurse when they were hired on medication administration, BG checks, and insulin administration. On December 12, 2023, at 11:59 a.m., the surveyor observed R1's lunchtime medication administration conducted by ULP-B. ULP-B used R1's glucometer to check R1's BG which was 152. ULP-B opened ECP to verify R1's Novolog FlexPen medication administration orders which indicated 5u of Novolog FlexPen insulin be administered for BG above 160. ULP-B compared the Novolog FlexPen pharmacy tag with the order in ECP. ULP-B dialed the Novolog FlexPen to 5u. ULP-B handed the Novolog FlexPen to R1 along with a needle to put on it. R1 put the needle on the Novolog FlexPen and prepared to administer it in their abdomen without priming it. The surveyor stopped ULP-B and R1 and asked ULP-B what the order was and what they were going to administer. ULP-B reviewed the order in ECP, she read the order out loud and stated based on the BG result of 152 they were going to administer 5u. The surveyor again requested clarification on how much insulin they were going to administer, ULP-B stated the order says to give 5u of insulin. ULP-B then stopped what they were doing and stated they were going to ask clinical nurse supervisor (CNS)-A to make sure they were administering the correct dose of insulin. CNS-A looked at the order in ECP and asked ULP-B what R1's BG reading was. ULP-B stated it was 152. CNS-A stated no insulin should not be administered since R1's BG reading was less than 160. ULP-B stated this was how they had been interpreting the order whenever they	01760			

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01760	Continued From page 53 administered R1's Novolog FlexPen insulin. On December 12, 2023, at 3:04 p.m., CNS-A stated ULP-B had not followed their medication administration policy and procedures when administering R1's medication on December 11, 2023. CNS stated ULP-B should have completed the seven rights of medication administration per their policy (checking right client, day, time, dose, route, location of injection, and checking for additional instructions) using ECP as an order could have changed since they last administered the medication. CNS-A stated ULP-B should also have checked R1's Novolog FlexPen against the MAR in ECP. CNS-A stated ULP-B needed to check ECP while conducting the medication administration. CNS-A stated ULP-B should have attached the needle to the Novolog FlexPen, primed it with 2u and then handed it to R1. CNS-A stated ULP-B had been trained, competencied, and demonstrated medication administration, BG checks and insulin administration by CNS-A. CNS-A stated the sliding scale may have caused confusion for ULP-B due to the greater than and less than (< >) signs used in the order description. ULP-B's Employee Training Log, dated with the supervisor verification initials on December 3, 2018, indicated they received medication administration, BG testing, insulin pen and administration training on November 21, 2018. The manufacturer instructions for Novo Nordisk Novolog FlexPen revised in February 2015, indicated to prime the FlexPens newly attached needle with 2u of insulin. The licensee's Insulin Pen Medication Protocol with a Reusable Pen procedure for R1 dated July	01760			

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01760	Continued From page 54 1, 2023, indicated: "3. Check medication profile: a. right client b. right day c. right time d. right dose e. right route f. location of last injection site g. check for additional instructions 9. If required, prime the needle by following the manufacturer's instructions. This might mean dialing 2 units of insulin, pressing the injection button and watching for a drop of insulin to appear on the tip of the needle. This drop shows that there is no air in the system. 12. Depending on client ability, have the client dial the correct dose of insulin. If the client is unable to dial the correct dose, dial it following the RN's instructions and using the dial function on the pen. 13. If possible, ask the client to double check the insulin dose that has been dialed." The licensee's Medication Administration policy dated May 29, 2020, indicated: 3. The Registered Nurse may delegate medication administration to an unlicensed staff member (home health aide) according to the following protocol. a. All home health aides have passed a competency evaluation with respect to all medication routes to be administered b. The Registered Nurse has prepared written instructions for the home health aide in the proper methods to administer medications with respect to each client c. The Registered Nurse has communicated with/provided orientation to the home health aide regarding the individual needs of the client 6. All staff with responsibility for medication	01760			

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01760	Continued From page 55 administration have access to information about the medication being administered, including but not limited to: -Purpose -Dosage -Route -Frequency -Instructions related to the medication and specific to the clients, as appropriate -Side effects -Client allergies to medications No further information provided TIME PERIOD FOR CORRECTION: Seven (7) days	01760			
01820 SS=D	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to clarify instructions for use on a written or electronically recorded prescription for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at 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	01820			

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01820	Continued From page 56 only occasionally). The findings include: R1's service plan dated July 1, 2023, indicated R1 received medication management services. R1's Medication Management Services plan dated July 1, 2023, indicated the registered nurse (RN) or administrator were responsible for obtaining prescriptions and orders. R1's record included a prescription dated August 21, 2023, which indicated R1 took the following medication: -Lantus SoloStar 100 units (u)/milliliter (ml), Subcutaneous (SQ) solution pen-injector, inject 45-50u SQ (below the skin) every morning. R1's medication administration record (MAR) for December 2023, indicated R1 took: -Lantus SoloStar 3 ml prefilled pens, 100 u/ml inj (injection), inject 45-50u SQ every morning. The MAR did not provide instructions for staff to know when to administer 45u versus 50u. On December 12, 2023, at 11:33 a.m., the surveyor observed the medication cart with clinical nurse supervisor (CNS)-A. R1's Lantus SoloStar insulin pen pharmacy label indicated: -Lantus SoloStar 3 ml prefilled pens, 100 u/ml inj, inject 45-50u SQ every morning. On December 14, 2023, at 9:00 a.m., CNS-A stated R1's Lantus SoloStar insulin orders were not clarified with a specific dose or blood glucose (BG) parameters when it came to the facility. CNS-A stated R1 used to take 40u of the insulin prior to the new order. CNS-A stated they called and left their first message with the clinic, "almost	01820			

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01820	Continued From page 57 two months ago and I called and left another message just now." CNS-A stated they had been administering the lesser of the 45-50u, or 45u, until the order could be clarified. CNS-A stated they had, "verbally" instructed unlicensed personnel (ULPs) to administer 45u and did not have any documentation in R1's record or MAR for ULPs to follow. CNS-A stated it could be difficult to get order clarification from doctors as they did not always call back. CNS-A stated they would call again later today, December 14, 2023, if they had not heard back from the clinic. CNS-A stated it was their responsibility to make sure orders were accurate and clarified. On December 14, 2023, at 9:59 a.m., CNS-A stated they talked to the clinic, and they were sending a clarifying order to administer 50u of Lantus SoloStar insulin every morning. The licensee's Prescriber Orders policy dated May 29, 2020, indicated, "Global Case Management will maintain a current written or electronically recorded prescription for all prescribed medications managed for the client." The licensee's Coordination in the Medication Management Program policy dated May 29, 2020, indicated, "The RN or Licensed Health Professional is responsible for coordinating the Medication Management Program with other health care providers serving the client." It further indicated, "Activities of care coordination will be documented in the clinical record." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820			

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01880	Continued From page 58	01880			
01880 SS=D	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 prevent unauthorized access to refrigerated medications for one of one resident (R1) with refrigerated medications. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: On December 11, 2023, at 11:05 a.m., during the facility tour, the surveyor observed the kitchen refrigerator with licensed assisted living director (LALD)-D. They stated medications which required refrigeration were stored in the main refrigerator in the kitchen. They stated the medications were kept in one of the storage drawers of the refrigerator and was not locked. The refrigerator drawer included the following medications for R1: -Lantus SoloStar 3 milliliter (ml) prefilled pens, 100 units (u)/ml, two pens; and	01880			

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01880	Continued From page 59 -Novolog FlexPen 3 ml prefilled syringes, 100 u/ml, two pens. On December 12, 2023, at 3:04 p.m., LALD-D and clinical nurse supervisor (CNS)-A stated they were unaware medications stored in the refrigerator needed to be locked. LALD-D stated they thought as long as the medications were in their own compartment in the refrigerator then it was okay. LALD-D and CNS-A acknowledged all residents of the facility had access to R1's insulin pens stored in the refrigerator. The licensee's Storage/Control of Medications policy dated May 29, 2020, indicated, "Policy Statement: When Global Case Management is providing storage of medications outside of the client's private living space, all prescription drugs are securely locked in substantially constructed compartments according to the manufacturer's directions. Only authorized personnel have access to the stored medications." It further indicated, "8. Medications requiring refrigeration are clearly labeled and stored in an enclosed container or area separated from foods. Temperature is maintained at 35-40 degrees." No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880			
01890 SS=D	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	01890			

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01890	Continued From page 60 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 ensure medications were labeled with an opened-on date for one of two residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1's service plan dated July 1, 2023, indicated R1 received medication management services. R1's record included a prescription dated August 21, 2023, which indicated R1 took the following medication: -Lantus SoloStar 100 units (u)/milliliter (ml), Subcutaneous (SQ) solution pen-injector, inject 45-50u SQ (below the skin) every morning. On December 12, 2023, at 11:33 a.m., the surveyor observed the medication cart with clinical nurse supervisor (CNS)-A. The following medication lacked an opened-on date: -R1's Lantus SoloStar 3ml prefilled pens, 100u/ml, the manufacturer expiration date was covered by the pharmacy label. On December 12, 2023, at 11:33 a.m., CNS-A	01890			

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01890	Continued From page 61 acknowledged R1's Lantus SoloStar pen lacked an opened-on date and was currently in use to administer R1's Lantus orders. CNS-A stated they were aware of the opened-on date requirements and stated R1's other insulin pen, Novolog FlexPen 3 ml prefilled syringe, was labeled correctly with an opened-on and expiration date as observed by the surveyor. On December 12, 2023, at 11:59 a.m., unlicensed personnel (ULP)-B stated they were trained and knew they should label insulin pens with an opened-on date but was not the one who opened the new pen. On December 12, 2023, at 3:04 p.m., CNS-A stated they were throwing away R1's Lantus SoloStar pen which lacked an opened-on date and were opening a new one since they did not know when it was opened. CNS-A stated whoever opens an insulin pen should be the one to label it with the opened-on date and expiration date. CNS-A stated unlicensed personnel were trained to label the insulin pens when they opened a new one. The manufacturer's instructions for Lantus SoloStar 3 ml prefilled pens indicated once you take your SoloStar out of cool storage, for use or as a spare, you can use it for up to 28 days. The licensee's Storage/Control Medications policy dated May 29, 2020, indicated, "The licensed nurse is responsible for dating time-sensitive medications when opened." No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890			

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02290 SS=F	144G.91 Subd. 2 Legislative intent The rights established under this section for the benefit of residents do not limit any other rights available under law. No facility may request or require that any resident waive any of these rights at any time for any reason, including as a condition of admission to the facility. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee limited the rights of residents when the licensee required residents to sign and follow house rules. 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: R1's Assisted Living Service Plan dated July 1, 2023, indicated R1 received services for meal preparation, medication management, and mental health management. R1's Resident Contract for Assisted Living signed July 1, 2023, page eight and nine, section 16 Resident Policies, Rules and Regulations indicated, "By signing this Agreement, you agree to abide by and comply with all of the Community's policies, rules and regulations which have been provided to you. The Community reserves the right to adopt, amend and	02290			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33614	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/13/2023
NAME OF PROVIDER OR SUPPLIER GLOBAL CASE MANAGMENT		STREET ADDRESS, CITY, STATE, ZIP CODE 5231 BUCHANAN STREET NE FRIDLEY, MN 55421			
(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
02290	Continued From page 63 discontinue policies, rules and regulations. The Community will provide you with written notice of all such changes." The licensee's blank contract, undated, included the same statement. R1's Global Case Management House Rules form signed July 1, 2023, indicated: "1. We have open visiting hours between 10 a.m. And 6 p.m. 2. Residents and guests are expected to demonstrate respect, courtesy and manners by: a. avoiding profanity, loud discussions and topics generally considered inappropriate in mixed company. b. respecting the privacy of each resident. c. avoiding racial, ethnic and religious slurs or comments. d. keeping the volume of talking, radios, stereos and televisions at a level which is not distracting or intrusive. 3. Smoking is not permitted in the home. It is only permitted in the designated areas 4. Alcoholic beverages are not allowed in the care home or its premises. Inebriated individuals, including visitors, are not allowed in the care home or on its premises. 5. All medications-prescription and nonprescription-must be prescribed by the resident's physician (PA or NP) and the care home must have a written order from the physician before the medication can be used by the resident. Bringing medications into the care home and using them without a written physician's order is grounds for termination of the Residency Agreement. a. Medications include vitamins, minerals, antacids, pain medication, laxatives, stool softeners, herbal supplements and nutritional	02290			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33614	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/13/2023
NAME OF PROVIDER OR SUPPLIER GLOBAL CASE MANAGMENT		STREET ADDRESS, CITY, STATE, ZIP CODE 5231 BUCHANAN STREET NE FRIDLEY, MN 55421			
(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
02290	Continued From page 64 supplements. b. Nonprescription and over-the-counter drugs are the same. c. If the resident or the resident's representative provides medication and refills, prescriptions must be delivered to the facility in a timely manner. d. The manager can suggest pharmacies which will deliver and bill the resident or the resident's representative directly. 6. Menus are preplanned and may be reviewed by the resident, the resident's representative or family member upon request. Dietary planning and food preparation is done in consideration of the resident's dietary requirements. a. Special religious dietary needs must be arranged for by the resident or the resident's representative. b. The care home provides: i. Three meals and three snacks per day. ii. Food which is nutritious, attractive and appetizing. iii. Special diets as ordered by the physician and within reason as to cost. c. We invite the resident and the resident's representative to make suggestions, submit recipes and request special food items, meals or preparation to the manager. 7. Televisions, radios and stereos are permitted in the resident's room as long as they do not disturb other residents. Residents have the right to select programming of their choice on personal appliances. 8. In case of an emergency, the care home will make every effort to contact the resident's physician and act upon the physician's instructions. If the care home is unable to reach the physician, the care home will activate the Emergency Medical Services. a. A "No Resuscitation" or living will order	02290			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33614	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/13/2023
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02290	Continued From page 65 does not negate emergency treatment if there is injury or illness. b. A "No Resuscitation" or living will order is respected in terms of reviving a resident in the event of death and respecting their last wishes in the matter. 9. No pets are allowed. 10. The care home is not liable for injuries or other occurrences while the resident is away from the care home. Individuals taking residents from the care home will be requested to sign out and in to facilitate planning care for the resident. 11. Client must notify staff when going on leave with family or friends. Staff will make record of client LOA. 12. Possession or use of alcohol, drugs or weapons is strictly prohibited. Possession includes anywhere on the property. This includes any product that contains alcohol i.e., mouthwash, after-shave, over counter medicines, etc. All prescribed and over the counter drugs must be held and dispensed by staff. Violation will result in discharge." On December 12, 2023, at 9:20 a.m., licensed assisted living director (LALD)-D stated the house rules form was current and enforced. LALD-D stated all residents signed the same contract and house rules form. LALD-D stated the blank contract they provided was current and in use. LALD-D stated they were unaware they could not set these sorts of restrictions but understood how it could limit a resident's rights. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02290			

Type: Full
Date: 12/11/23
Time: 13:00:00
Report: 1013231282

Food and Beverage Establishment Inspection Report

Page 1

Location:

Global Case Managment
5231 Buchanan Street Ne
Fridley, MN55421
Anoka County, 02

Establishment Info:

ID #: 0038766
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7639996914
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.

3-300C Protection from Contamination: equipment/utensils, consumers**3-304.12B**

MN Rule 4626.0275B Store the food preparation and dispensing utensil in a food that is not TCS food with the handles above the top of the food within containers or equipment that can be closed such as bins of sugar, flour or cinnamon.

CUPS WITHOUT HANDLES WERE STORED IN CONTACT WITH THE FOOD INSIDE FOOD BINS (RICE, FLOUR). DISCUSSED UTENSIL STORAGE WITH STAFF AND THE CUPS WERE REMOVED. THE OPERATOR PLANS TO PURCHASE SCOOPS WITH HANDLES.

Corrected on Site

6-500 Physical Facility Maintenance/Operation and Pest Control**6-501.111ABD**

MN Rule 4626.1565ABD Provide control of insects, rodents, and other pests by routinely inspecting incoming food and supply shipments; routinely inspecting the premises for evidence of pests; and eliminating harborage conditions.

RODENT DROPPINGS WERE IN DRAWERS BELOW THE HAND WASHING SINK. DISCUSSED PEST CONTROL AND DETERRING PEST ACTIVITY WITH STAFF. STAFF CLEANED THE DRAWERS AND PEST CONTROL INVOICES WERE PROVIDED.

Comply By: 12/11/23

Surface and Equipment Sanitizers

Hot Water: = at 160 Degrees Fahrenheit
Location: Dish machine
Violation Issued: No

Food and Equipment Temperatures

Type: Full
Date: 12/11/23
Time: 13:00:00
Report: 1013231282
Global Case Managment

Food and Beverage Establishment Inspection Report

Process/Item: Ham
Temperature: 41 Degrees Fahrenheit - Location: Refrigerator
Violation Issued: No

Process/Item: Cheese
Temperature: 40 Degrees Fahrenheit - Location: Refrigerator
Violation Issued: No

Process/Item: Chicken
Temperature: 29 Degrees Fahrenheit - Location: Freezer
Violation Issued: No

Process/Item: Salmon
Temperature: 147 Degrees Fahrenheit - Location: Air fryer - final cook temperature
Violation Issued: No

Process/Item: Salmon
Temperature: 6 Degrees Fahrenheit - Location: Freezer 2
Violation Issued: No

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

The inspection was completed with the operator then reviewed with MDH Nurse Evaluators J. Keen and D. Mosissa.

The establishment has a residential kitchen and serves food that is prepared that day. The kitchen has wood cabinets, wood floor, painted walls, solid counter top, and a textured ceiling.

A designated hand washing sink is located in the kitchen.

A residential dish machine is used to wash ware. The dish machine is run on the sanitize cycle.

Discussed hand washing, ware washing, staff illness policy, temperature control, final cook temperatures, cleaning, serving highly susceptible populations, and food handling procedures.

Type: Full
Date: 12/11/23
Time: 13:00:00
Report: 1013231282
Global Case Managment

Food and Beverage Establishment Inspection Report

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 1013231282 of 12/11/23.

Certified Food Protection Manager Ifrah Abshir

Certification Number: 108755 Expires: 12/06/24

Inspection report reviewed with person in charge and emailed.

Signed: _____
Yasin Abshir
Operator

Signed: JM _____
Jerry Malloy
Sanitarian Supervisor
FPLS Metro
651-201-3998
jerry.malloy@state.mn.us