



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

October 16, 2024

Licensee
Eden Homes Inc
7411 Queen Avenue South
Richfield, MN 55423

RE: Project Number(s) SL33757015

Dear Licensee:

On October 14, 2024, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on July 31, 2024. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the July 31, 2024 survey.

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

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on July 31, 2024, found not corrected at the time of the October 14, 2024, follow-up survey and/or subject to penalty assessment are as follows:

0470-Minimum Requirements-144g.41 Subdivision 1 - \$500.00
1500-Required Annual Training-144g.63 Subd. 5- \$500.00

The details of the violations noted at the time of this follow-up survey completed on October 14, 2024 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$1,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

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

IMPOSITION OF FINES:

Level 1: no fines or enforcement.

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

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

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

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

REQUESTING A HEARING

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

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

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

We urge you to review these orders carefully. If you have questions, please contact Jodi Johnson at 507-344-2730.

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,



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

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33757	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 10/14/2024
NAME OF PROVIDER OR SUPPLIER EDEN HOMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 7411 QUEEN AVENUE SOUTH RICHFIELD, MN 55423		
(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: SL33757015-1 On October 14, 2024, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on July 31, 2024. At the time of the survey, there were three residents; three receiving services under the Assisted Living license. As a result of the follow-up survey, the following orders were reissued.	{0 000}	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
{0 470} SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for	{0 470}			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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{0 470}	Continued From page 1 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; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the required staffing plan was developed as required, potentially affecting the licensee's residents, staff, and any visitors of the licensee. This practice resulted in a level two violation (a violation that did not harm a licensee's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	{0 470}			

Minnesota Department of Health

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{0 470}	Continued From page 2 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 held an assisted living license and was licensed for a capacity of four residents with a current census of three residents. On October 14, 2024, at 11:25 a.m. the facility staffing plan was requested. Licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated she still had not created a staffing plan. The licensee failed to develop and implement a staffing plan for determining its staffing level that: - included an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility. No further information was provided.	{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: Not reviewed during this survey.	{0 480}			

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{0 780}	Continued From page 3	{0 780}			
{0 780} SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{0 780}			
{0 790} SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code;	{0 790}			

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{0 790}	Continued From page 4 (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{0 790}			
{0 810} SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in	{0 810}			

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{0 810}	Continued From page 5 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: Not reviewed during this survey.	{0 810}			
{01500} SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment;	{01500}			

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

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{01500}	Continued From page 7 training included all required topics for each 12 months of employment for two of two employees (registered nurse (RN)-B, unlicensed personnel (ULP)-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: RN-B RN-B was hired on November 1, 2012, to provide direct care services to the licensee's residents. On October 14, 2024, at 12:15 p.m. RN-B was observed to interact with R1 and R3 in their rooms. RN-B's record lacked evidence of review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures. ULP-D ULP-D was hired on May 15, 2018, to provide direct care services to the licensee's residents. On October 14, 2024, at 12:15 p.m. licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated ULP-D primarily worked at the licensee's other facility; but was on call for this facility. ULP-D's Educare (online training program)	{01500}			

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{01500}	Continued From page 8 transcript dated October 14, 2024, lacked a review of infection control techniques used in the home and implementation of infection control standards, as required annual training. Furthermore, ULP-D's record lacked evidence of review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures. On October 14, 2024, at 12:30 p.m. LALD/CNS-A stated she assigned the annual training topics in Educare for the employees. She stated she and the employees reviewed the facility's policies and procedures with meetings and when they pertain to specific residents; however, she did not have record of these meetings or discussions and needed to figure out a way to document this training to meet requirements for her employees. Furthermore, LALD/CNS-A stated ULP-D's annual training was missing the required infection control training. The licensee's Annual Training policy dated July 2024, indicated all staff that provide direct care services in assisted living must complete at least eight (8) hours of annual training for each 12 months of employment. Training must include: 3. Review of infection control techniques used in the home and implementation of infection control standards including: a. A review of hand-washing techniques b. Need for and use of protective gloves, gowns, and masks c. Appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades d. disinfecting reusable equipment e. Disinfecting environmental surfaces	{01500}			

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{01500}	Continued From page 9 f. Reporting of communicable diseases 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 No further information was provided.	{01500}			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

August 23, 2024

Licensee
Eden Homes Inc
7411 Queen Avenue South
Richfield, MN 55423

RE: Project Number(s) SL33757015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 31, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

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

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

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

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **<https://forms.office.com/g/Bm5uQEPhVa>**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,



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

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NAME OF PROVIDER OR SUPPLIER EDEN HOMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 7411 QUEEN AVENUE SOUTH RICHFIELD, MN 55423		
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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: SL33757015-0 On July 29, 2024, through July 31, 2024, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were three residents; three receiving services under the provider's Assisted Living Facility license. 2310: An immediate correction order was issued on July 30, 2024. The immediacy was removed on July 30, 2024; however, non-compliance remains at a level 2, widespread scope (F).	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
0 130 SS=F	144G.12, Subd. 1 Application for Licensure Each application for an assisted living facility	0 130			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33757	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/31/2024
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0 130	Continued From page 1 license, including provisional and renewal applications, must include information sufficient to show that the applicant meets the requirements of licensure, including: (1) the business name and legal entity name of the licensee, and the street address and mailing address of the facility; (2) the names, e-mail addresses, telephone numbers, and mailing addresses of all owners, controlling individuals, managerial officials, and the assisted living director; (3) the name and e-mail address of the managing agent and manager, if applicable; (4) the licensed resident capacity and the license category; (5) the license fee in the amount specified in section 144.122; (6) documentation of compliance with the background study requirements in section 144G.13 for the owner, controlling individuals, and managerial officials. Each application for a new license must include documentation for the applicant and for each individual with five percent or more direct or indirect ownership in the applicant; (7) evidence of workers' compensation coverage as required by sections 176.181 and 176.182; (8) documentation that the facility has liability coverage; (9) a copy of the executed lease agreement between the landlord and the licensee, if applicable; (10) a copy of the management agreement, if applicable; (11) a copy of the operations transfer agreement or similar agreement, if applicable; (12) an organizational chart that identifies all organizations and individuals with an ownership interest in the licensee of five percent or greater	0 130			

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0 130	Continued From page 2 and that specifies their relationship with the licensee and with each other; (13) whether the applicant, owner, controlling individual, managerial official, or assisted living director of the facility has ever been convicted of: (i) a crime or found civilly liable for a federal or state felony level offense that was detrimental to the best interests of the facility and its resident within the last ten years preceding submission of the license application. Offenses include: felony crimes against persons and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pretrial diversions; financial crimes such as extortion, embezzlement, income tax evasion, insurance fraud, and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pretrial diversions; any felonies involving malpractice that resulted in a conviction of criminal neglect or misconduct; and any felonies that would result in a mandatory exclusion under section 1128(a) of the Social Security Act; (ii) any misdemeanor conviction, under federal or state law, related to: the delivery of an item or service under Medicaid or a state health care program, or the abuse or neglect of a patient in connection with the delivery of a health care item or service; (iii) any misdemeanor conviction, under federal or state law, related to theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service; (iv) any felony or misdemeanor conviction, under federal or state law, relating to the interference with or obstruction of any investigation into any criminal offense described in Code of Federal Regulations, title 42, section 1001.101 or	0 130			

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0 130	Continued From page 3 1001.201; (v) any felony or misdemeanor conviction, under federal or state law, relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance; (vi) any felony or gross misdemeanor that relates to the operation of a nursing home or assisted living facility or directly affects resident safety or care during that period; (vii) any revocation or suspension of a license to provide health care by any state licensing authority. This includes the surrender of such a license while a formal disciplinary proceeding was pending before a state licensing authority; (viii) any revocation or suspension of accreditation; or (ix) any suspension or exclusion from participation in, or any sanction imposed by, a federal or state health care program, or any debarment from participation in any federal executive branch procurement or nonprocurement program; (14) whether, in the preceding three years, the applicant or any owner, controlling individual, managerial official, or assisted living director of the facility has a record of defaulting in the payment of money collected for others, including the discharge of debts through bankruptcy proceedings; (15) the signature of the owner of the licensee, or an authorized agent of the licensee; (16) identification of all states where the applicant or individual having a five percent or more ownership, currently or previously has been licensed as an owner or operator of a long-term care, community-based, or health care facility or agency where its license or federal certification has been denied, suspended, restricted, conditioned, refused, not renewed, or revoked	0 130			

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0 130	Continued From page 4 under a private or state-controlled receivership, or where these same actions are pending under the laws of any state or federal authority; (17) statistical information required by the commissioner; and (18) any other information required by the commissioner. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to execute a written assisted living (AL) contract with required content for all persons living in the building. 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: 144G.33 INNOVATION VARIANCE. Subdivision 1. Definition; granting variances. (a) For purposes of this section, "innovation variance" means a specified alternative to a requirement of this chapter. (b) An innovation variance may be granted to allow an assisted living facility to offer services of a type or in a manner that is innovative, will not impair the services provided, will not adversely affect the health, safety, or welfare of the residents, and is likely to improve the services provided. The innovative variance cannot change any of the resident's rights under the assisted	0 130			

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0 130	Continued From page 5 living bill of rights. Subd. 4. Applications; innovation variance. An application for innovation variance from the requirements of this chapter may be made at any time, must be made in writing to the commissioner, and must specify the following: (1) the statute or rule from which the innovation variance is requested; (2) the time period for which the innovation variance is requested; (3) the specific alternative action that the licensee proposes; (4) the reasons for the request; and (5) justification that an innovation variance will not impair the services provided, will not adversely affect the health, safety, or welfare of residents, and is likely to improve the services provided. On July 29, 2024, at 11:00 a.m. licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the assisted living facility was a five-bedroom home, was licensed for four residents, with a current census of three residents (one of the three was currently hospitalized). Additionally, LALD/CNS-A stated the licensee's parents (mother and father) also resided in the facility in the lower level. The mother was a registered nurse and one of the facility's employees. The licensee failed to provide a written contract for those receiving housing services at the facility. Minnesota Assisted Living Statutes 144G.08 definitions indicated: - Subd. 5. Assisted living contract-"Assisted living contract" means the legal agreement between a resident and an assisted living facility for housing, and if applicable, assisted living services;"	0 130			

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0 130	Continued From page 6 - Subd. 7. Assisted living facility- "Assisted living facility" means a facility that provides sleeping accommodations and assisted living services to one or more adults. Refer to clauses 1-15 for exclusions. - Subd. 59. Resident. -"Resident" means an adult living in an assisted living facility who has executed an assisted living contract. On July 29, 2024, at 11:30 a.m. LALD/CNS-A stated the licensee's parents/owners of the facility, started living in the facility during COVID to minimize contact with others in the community and had continued to live there. LALD/CNS-A stated she was not aware a license variance was required but would apply for a variance. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 130			
0 250 SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident;	0 250			

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0 250	Continued From page 7 (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4, or interferes with or impedes access by the Office of Ombudsman for Mental Health and Developmental Disabilities according to section 245.94, subdivision 1; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility.	0 250			

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0 250	Continued From page 8 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to show they met the requirements of licensure, by attesting the managerial officials who oversaw the day-to-day operations understood applicable statutes and rules; nor developed and/or implemented current policies and procedures as required with records reviewed. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on July 29, 2024, at 11:30 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee's employees in charge of the facility were familiar with the assisted living regulations and the licensee provided medication and treatment management services. The licensee's Application for Assisted Living License, section titled Official Verification of Owner or Authorized Agent, (page four and five of the application), identified, I certify I have read and understand the following: [a check mark was placed before each of the following]:	0 250			

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0 250	Continued From page 9 - I have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section] 144G.45, my building(s) must comply with subdivisions 1-3 of the section, as applicable section Laws 2020, 7th Spec. [special] Sess [session]., chpt. [chapter] 1. art. [article] 6, sect. 17. - I have read and fully understand Minn. Stat. sect. 144G.80, 144G.81. and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22, my building(s) must comply with these sections if applicable. - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G. - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659. - Reporting of Maltreatment of Vulnerable Adults. - Electronic Monitoring in Certain Facilities. - I understand pursuant to Minn. Stat. sect. 13.04 Rights of Subjects of Data, the Commissioner will use information provided in this application, which may include an in-person or telephone conference, to determine if the applicant meets requirements for assisted living licensing. I understand I am not legally required to supply the requested information; however, failure to provide information or the submission of false or misleading information may delay the processing of my application or may be grounds for denying a license. I understand that information submitted to the commissioner in this application may, in some circumstances, be disclosed to the appropriate state, federal or local agency and law enforcement office to enhance investigative or	0 250			

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0 250	Continued From page 10 enforcement efforts or further a public health protective process. Types of offices include Adult Protective Services, offices of the ombudsmen, health-licensing boards, Department of Human Services, county or city attorneys' offices, police, local or county public health offices. - I understand in accordance with Minn. Stat. sect. 144.051 Data Relating to Licensed and Registered Persons (opens in a new window), all data submitted on this application shall be classified as public information upon issuance of a provisional license or license. All data submitted are considered private until MDH issues a license. - I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659 governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. - I have examined this application and all attachments and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct, and complete. I will notify MDH, in writing, of any changes to this information as required. - I attest to have all required policies and procedures of Minn. Stat. chapter 144G and	0 250			

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0 250	Continued From page 11 Minn. Rules chapter 4659 in place upon licensure and to keep them current as applicable. Page six was electronically signed by licensed assisted living director (LALD)-C on March 20, 2024. The licensee had an assisted living license issued on June 1, 2024, with an expiration date of May 31, 2025. The licensee failed to ensure the following policies and procedures were developed and/or implemented: - requirements in section 626.557, reporting of maltreatment of vulnerable adults; - conducting and handling background studies on employees; - orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; - handling complaints regarding staff or services provided by staff; - conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate; - orientation to and implementation of the assisted living bill of rights; - conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards; - medication and treatment management; - delegation of tasks by registered nurses or licensed health professionals;	0 250			

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0 250	Continued From page 12 As a result of this survey, the following orders were issued 0550, 0630, 0650, 0660, 1290, 1500, 1530, 1620, 1730, 1880, 1890, 1940 and 2310, indicating the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.08 to 144G.95. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 250			
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans 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	0 470			

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0 470	Continued From page 13 amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the required staffing plan was developed as required, potentially affecting the licensee's residents, staff, and any visitors of the licensee. This practice resulted in a level two violation (a violation that did not harm a licensee'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 held and assisted living license and was licensed for a capacity of four residents with a current census of three residents. On July 29, 2024, at 12:30 p.m. during entrance conference, the facility staffing plan was requested. Licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated she had not created a staffing plan. The licensee failed to develop and implement a staffing plan for determining its staffing level that: - included an evaluation, to be conducted at least twice a year, of the appropriateness of staffing	0 470			

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NAME OF PROVIDER OR SUPPLIER EDEN HOMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 7411 QUEEN AVENUE SOUTH RICHFIELD, MN 55423		
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0 470	Continued From page 14 levels in the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 470			
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated July 29, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480			

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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: Based on observation, interview, and record review, the licensee failed to post the required information related to the grievance procedure as well as the required information related to the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that	0 550			

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0 550	Continued From page 16 has affected or has the potential to affect a large portion or all of the residents). The findings include: On July 29, 2024, at 11:30 a.m. the surveyor observed the facility postings located on the wall in the facility living room; however, the complaint procedure and contact information for the Ombudsman was not found. On July 29, 2024, at 11:35 a.m. licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A provided the surveyor with the licensee's grievance procedure and stated the grievance procedure was included with the resident's admission paperwork; however, the posting was not yet placed as required. Furthermore, the licensee's grievance procedure lacked the content to include the licensee's email address for resident complaints as required. The licensee failed to post the required information about the facility's grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. Additionally, the posting lacked contact information for the Office of Ombudsman for Mental Health and Developmental Disabilities. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 550			
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management	0 580			

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0 580	Continued From page 17 appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to implement and maintain a quality management program appropriate to the size of the facility and relevant to the type of services provided. This had the potential to affect all current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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 July 29, 2024, at 12:00 p.m. during the entrance conference, licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated that although the licensee's leadership team met regularly and discussed topics, they did	0 580			

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0 580	Continued From page 18 not have a formal quality management program, nor had the licensee taken notes with meetings. The licensee's Quality Management Program policy dated July 2024, indicated the facility shall develop a continuous quality management program to identify, support and maintain the facility's quality improvement efforts and provide quality services to our residents. All staff will be involved in the implementation of performance improvement activities. Outcome measurement of these activities will be monitored on a continuous basis and all results will be reported, at least annually, to the management team. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 580			
0 630 SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	0 630			

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0 630	Continued From page 19 review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for two of two residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 R1's diagnoses included diabetes, depression, and alcohol abuse. R1 was admitted to the facility on October 25, 2018. R1's unsigned, Service Plan dated July 29, 2024, indicated R1 received services including medication administration, blood sugar checks, assistance with bathing, grooming, transfers, behavior management and vital signs. On July 30, 2024, at 9:05 a.m. registered nurse (RN)-B was observed to set up and administer R1's oral medications and complete a set of vital signs (temperature, oxygen saturation, pulse, and blood pressure). R1's IAPP found in the comprehensive assessment dated May 8, 2024, indicated R1's risk for abuse by others including other vulnerable adults, her risk for self-abuse and included interventions to minimize these risks; however,	0 630			

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0 630	Continued From page 20 R1's IAPP lacked an indication of her susceptibility to abuse others including other vulnerable adults. R2 R2's diagnoses included diabetes, depression, and asthma. R2 was admitted to the facility on October 25, 2018. R2's unsigned, Service Plan dated July 29, 2024, indicated he received services to including medication administration, behavior management, blood sugar checks, assistance with bathing, grooming, and toileting. On July 29, 2024, at 12:45 p.m. licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated R2 was currently in the hospital and had been receiving services from the licensee since 2018. R2's IAPP found in the comprehensive assessment dated March 14, 2024, included R2's susceptibility to abuse by others including other vulnerable adults, his risk for self-abuse and interventions to minimize these risks; however, R2's IAPP lacked an indication of his susceptibility to abuse others including other vulnerable adults. On July 30, 2024, at 1:15 p.m. LALD/CNS-A stated she was not aware the IAPP required content was to include the resident's susceptibility to abusing others and the need to include interventions to limit the risk to others including other vulnerable adults. The licensee's Vulnerable Adult policy dated July	0 630			

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0 630	Continued From page 21 30, 2024, indicated all residents admitted to the facility will be assessed for their susceptibility to abuse by other individuals, including other vulnerable adults and their risk of abusing other vulnerable adults. The facility will develop a statement of the specific measures that will be taken to minimize the risk of abuse to that person and other vulnerable adults. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630			
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for 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, interview, and record review, the licensee failed to support protection and safety by not posting information and phone numbers for reporting to the Minnesota Adult Abuse Reporting Center (MAARC) as required. This had the potential to affect all residents, staff,	0 640			

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0 640	Continued From page 22 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 July 29, 2024, at 11:30 a.m. the surveyor observed postings on the upper/main level of the facility and noted the facility lacked the required information and phone numbers for reporting to MAARC. On July 29, 2024, at 11:35 a.m. licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated she had not realized the requirement to post this information. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 640			
0 650 SS=F	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure,	0 650			

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0 650	Continued From page 23 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 contained the required content for one of one employee (registered nurse (RN)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: RN-B started employment on November 1, 2012. On July 30, 2024, at 9:05 a.m. RN-B was	0 650			

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0 650	Continued From page 24 observed to administer medications to R1. RN-B's employee record lacked evidence of documentation of annual performance reviews that identified areas of improvement needed and training needs and a job description. On July 30, 2024, at 1:40 p.m. licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated RN-B had not had an annual performance review and added, no employees received an annual performance review. Furthermore, LALD/CNS-A was unable to locate a job description for RN-B. The licensee's Performance Evaluation policy dated July 2024, indicated a competency-based performance evaluation will be conducted for all employees after one (1) year of employment and at least annually thereafter. The licensee's Job Description policy dated July 2024, indicated a description of each job shall be written using information obtained from a job analysis. The description will emphasize the essentials of the job and be clearly and concisely written, using standard terminology. The job description should define the minimum qualifications an employee needs to perform this job. This should include areas such as health, education, experience, job knowledge, registration, licensure, and certification requirements. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650			

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0 660	Continued From page 25	0 660			
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included a facility TB risk assessment, or documentation of a completed health history and symptom screening for one of one employee (registered nurse (RN)-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 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	0 660			

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0 660	Continued From page 26 portion or all of the residents). The findings include: TB PREVENTION PROGRAM On July 29, 2024, at 12:30 p.m. the surveyor requested the licensee's TB Risk Assessment. On July 30, 2024, at 11:00 a.m. the surveyor received the licensee's TB Risk Assessment Worksheet for Health Care settings and was dated July 29, 2024. The TB Risk Assessment indicated the licensee was a low-risk health care setting. The TB Risk Assessment included a hand-written note that indicated the licensee had no previously completed TB Risk Assessments. On June 30, 2024, at 2:00 p.m. licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A indicated she and LALD-C managed the licensee's TB Risk Assessment for the facility. LALD/CNS-A stated she completed the facility's TB Risk Assessment that day as there was not one completed prior. RN-B RN-B's employee record indicated a hire date of November 1, 2012, to provide direct care services to the licensee's residents. On July 30, 2024, at 9:05 a.m. RN-B was observed to set up and administer medications to R1. RN-B's employee file included a QuantiFERON blood test (a blood test to detect TB) dated June 14, 2021, with a negative result; however, RN-B's employee record lacked a completed a symptom screening related to the testing completed on June 14, 2021, or thereafter.	0 660			

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0 660	Continued From page 27 On July 30, 2024, at 2:00 p.m. (LALD/CNS)-A stated she was not sure whether RN-B's TB symptom screening had been completed and did not have record of one. The licensee's Tuberculosis Prevention and Control Policy dated July 2024, indicated the facility will complete the Community TB Risk Assessments annually. The licensee's Tuberculosis Screening Policy dated July 2024, indicated each employee or volunteer having direct contact with residents must have documentation of baseline health symptom screening prior to providing care to residents. This includes, at a minimum, the health symptom screening, TB skin testing via the Mantoux method. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660			
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	0 780			

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NAME OF PROVIDER OR SUPPLIER EDEN HOMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 7411 QUEEN AVENUE SOUTH RICHFIELD, MN 55423		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 780	Continued From page 28 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 that 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: On July 31, 2024, at 1:00 p.m., survey staff toured the facility with the facility with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A, registered nurse (RN)-B, and licensed assisted living director (LALD)-C. During	0 780			

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0 780	Continued From page 29 the facility tour, it was observed the sleeping rooms that were equipped with smoke alarms were not interconnected upon testing so actuation of one alarm would cause all alarms to operate. During the interview on July 31, 2024, at 1:30 p.m., LALD-C stated the smoke alarms in the facility were not interconnected, and the actuation of one alarm would not cause all alarms to operate. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780			
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to perform the required annual maintenance on fire extinguishers. This had the potential to affect all current residents, staff, and visitors.	0 790			

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0 790	Continued From page 30 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 July 31, 2024, at 1:00 p.m., survey staff toured the facility with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A, registered nurse (RN)-B, and licensed assisted living director (LALD)-C. During the facility tour, it was observed the fire extinguishers on all level did not have a service tag showing it had been inspected annually. During the interview on July 31, 2024, at 1:30 p.m., LALD-C stated the required annual maintenance had not been completed. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790			
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	0 810			

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0 810	Continued From page 31 residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on the interview and record review, the licensee failed to develop the fire safety and evacuation plan with the required content, failed to provide the required training, and failed to provide the required drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety, but was not likely to cause serious injury, impairment, or death), and	0 810			

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0 810	Continued From page 32 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 July 31, 2024, at 2:00 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A, registered nurse (RN)-B, and licensed assisted living director (LALD)-C 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 did not show the number of resident rooms, and resident rooms were not identified by number. Record review of the available documentation indicated that the licensee did not have fire protection procedures necessary for residents included in the fire safety and evacuation plan. During the interview on July 31, 2024, at 2:30 p.m., LALD-C verified the facility needed to update the fire safety and evacuation plan with the number of resident rooms. LALD-C also confirmed that the facility has a fire safety policy for staff but has not developed the necessary fire protection procedures for residents. TRAINING Record review of the available documentation indicated employees did not receive training twice per year after initial hire. During the interview on July 31, 2024, at 2:30	0 810			

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0 810	Continued From page 33 p.m., LALD-C 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-C confirmed there was no further documented training for the staff on the fire safety and evacuation plan as required by statute. DRILLS Record review of the available documentation indicated that the licensee did not conduct evacuation drills twice per year per shift and every other month as required by statute. Provided documentation indicated that the drills were conducted on 6/29/2024 and 12/10/2023, with no further drills being documented. During the interview on July 31, 2024, at 2:30 p.m., LALD-C confirmed that the drills were conducted every six months only and verified there were no further documented drills for the facility. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810			
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the	01060			

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01060	Continued From page 34 location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with required content for an emergency relocation and failed to notify the Office of Ombudsman for Long-Term Care of the emergency relocation for one of one resident (R2).	01060			

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01060	Continued From page 35 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: R2 R2 was admitted to the facility on October 25, 2018. R2's unsigned, Service Plan dated July 29, 2024, indicated he received services to including medication administration, behavior management, blood sugar checks, assistance with bathing, grooming, and toileting. R2s progress notes dated June 29, 2024, through July 29, 2024, indicated R2 was hospitalized following a fall on June 29, 2024, had a tibia/fibula fracture requiring surgical intervention, and post-hospital care at a transitional care unit, where he continued to receive care. On July 29, 2024, at 12:45 p.m. licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated R2 was currently in the hospital and had been receiving services from the licensee since 2018. R2's record lacked a written notice that contained, at a minimum: - the reason for the relocation;	01060			

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01060	Continued From page 36 - the name and contact information for the location to which the resident has been relocated and any new service provider; - contact information for the Office of Ombudsman for Long-Term Care; - if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; - a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. In addition, R2's records lacked notification to the Office of Ombudsman for Long-Term Care the resident had been relocated and had not returned to the facility within four days. On July 29, 2024, at 3:50 p.m. licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated she was not aware of the required notice of the emergency relocation and notice to the Office of Ombudsman for Long-Term Care; thus, had not completed the required notice nor made the notifications. The licensee's Contract Terminations policy dated July 2024, in the section labeled Emergency Relocation, indicated 2. In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: a. The reason for the relocation b. The name and contact information for the location to which the resident has been relocated and any new service provider c. Contact information for the Office of Ombudsman for Long-Term Care	01060			

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01060	Continued From page 37 d. If known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known e. A statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54; the facility must provide contact information for the agency to which the resident may submit an appeal f. The notice of emergency relocation must be delivered as soon as practicable to: 1. The resident, legal representative, and designated representative 2. For residents who receive waived services under chapter 256S and 256B.49, the resident's case manager 3. The Office of the Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. No further information was provided. TIME PERIOD TO CORRECT: Twenty-one (21) days.	01060			
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	01290			

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01290	Continued From page 38 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 three of six employees (unlicensed personnel (ULP)-D, ULP-E, ULP-F) were affiliated with the assisted living license as required. This had the potential to affect the licensee's three current 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: On July 30, 2024, at 10:25 a.m. the surveyor received the licensee's employee roster. ULP-D ULP-D was hired on November 1, 2012, to provide direct care services to the licensee's residents. ULP-E ULP-E was hired on November 1, 2012, to provide direct care services to the licensee's residents.	01290			

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01290	Continued From page 39 ULP-F ULP-F was hired on September 16, 2021, to provide direct care services to the licensee's residents. The licensee's Department of Human Services (DHS) NETStudy 2.0 roster dated July 30, 2024, indicated ULP-D, ULP-E, and ULP-F had cleared background studies; however, all three employees were affiliated with the licensee's other assisted living facility. ULP-D, ULP-E, and ULP-F's records lacked evidence the licensee affiliated a background study for their assisted living facility license. On July 30, 2024, at 10:30 a.m. licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated ULP-C, ULP-D and ULP-E all were on call for the licensee's facility and worked only occasionally at this site. LALD/CNS-A stated background studies were associated with her other licensed facility's license and was unaware the staff needed to be affiliated with both locations. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290			
01500 SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual	01500			

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01500	Continued From page 40 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 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;	01500			

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01500	Continued From page 41 (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 annual training included all required topics for each 12 months of employment for one of one employee (registered nurse (RN)-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 a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: RN-B was hired on November 1, 2012, to provide direct care services to the licensee's residents. On July 30, 2024, at 9:05 a.m. RN-B was observed to set up and administer R1's medications and complete vital signs (temperature, blood pressure, oxygen saturation, and pulse). RN-B's Educare (online training program)	01500			

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01500	Continued From page 42 transcript printed on July 30, 2024, indicated July 13, 2022, as the last date any training was completed. RN-B's record lacked the required eight hours of annual training for 2023. Furthermore, the record lacked the required annual training content to include: - training on reporting of maltreatment of vulnerable adults under section 626.557; - review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; - review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; - effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; - review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. On July 30, 2024, at 1:40 p.m. licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated RN-B had not completed any annual training since the latest date on her	01500			

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01500	Continued From page 43 Educare transcript, and no other staff had completed their annual training as required. LALD/CNS-A stated she set up the online training courses for staff to complete and was behind. The licensee's Annual Training policy dated July 2024, indicated all staff that provide direct care services in assisted living must complete at least eight (8) hours of annual training for each 12 months of employment. Training must include: 1. Training on reporting of maltreatment of vulnerable adults under section 626.557 2. Review of the Assisted Living Bill of Rights and staff responsibilities related to ensuring the exercise and protection of those rights 3. Review of infection control techniques used in the home and implementation of infection control standards including: a. A review of hand-washing techniques b. Need for and use of protective gloves, gowns, and masks c. Appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes and razor blades d. Disinfecting reusable equipment e. Disinfecting environmental surfaces f. Reporting of 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 6. The principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person	01500			

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01500	Continued From page 44 7. 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. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500			
01530 SS=F	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter;	01530			

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01530	Continued From page 45 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of one employee (registered nurse (RN)-B) received the required dementia care training. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: RN-B was hired on November 1, 2012, to provide direct care services to residents of the facility. On July 29, 2024, at 9:05 a.m. RN-A was observed to set up and administer R1's medications and complete vital signs (temperature, blood pressure, pulse, and oxygen saturations). RN-B's Educare (online training platform) training transcript printed on July 20, 2024, indicated she received the required (eight) dementia training hours and topics in 2021, and the required minimum two hours of dementia training in 2022; however, her record lacked evidence of two hours of dementia training was completed in 2023. On July 30, 2024, at 1:40 p.m. licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated RN-B had not completed any further dementia training annually as required	01530			

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01530	Continued From page 46 since July 12, 2022. The licensee's Dementia Care Training policy dated July 2024, indicated direct care employees must have completed at least eight hours of initial training on the required topics in the 160 hours from employment. Until this training is complete, the employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements or a supervisor meeting the requirements must be available for consultation with the new employee until the training requirement is complete. The policy did not include include the requirement for direct care staff to complete two hours of dementia training annually. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01530			
01620 SS=E	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs	01620			

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01620	Continued From page 47 and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed a comprehensive assessment for a change of condition for one of two residents (R1). Furthermore, the licensee failed to complete a reassessment not to exceed 90 days for two of two residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at 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: CHANGE IN CONDITION R1 R1 was admitted to the facility under the	01620			

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01620	Continued From page 48 comprehensive license on October 25, 2018, and later the assisted living license on August 1, 2021. R1's unsigned, Service Plan dated July 29, 2024, indicated R1 received services including medication administration, blood sugar checks, assistance with bathing, grooming, transfers, behavior management and vital signs. R1's progress notes dated March 13, 2024, indicated R1 had a left foot non-displaced fracture of the 5th metatarsal (foot bone), following a fall at her daughter's home. The licensee's RN failed to complete an assessment for a change in condition. On July 30, 2024, at 10:35 a.m. licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated she had not considered completing an assessment for a change in condition following R1's reported fall, pain, and confirmed foot fracture. 90 DAY REASSESSMENTS R1 On July 29, 2024, at 3:15 a.m. R1's last three Comprehensive Assessments were requested. Comprehensive Assessments dated November 10, 2023, January 23, 2024, and May 8, 2024, were provided. The May 8, 2024, assessment was 106 days after the previous assessment date, exceeding 90 calendar days. R2 R2 began receiving services under the licensee's comprehensive license on October 25, 2024, and later under the licensee's assisted living license since August 1, 2021.	01620			

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01620	Continued From page 49 R2's unsigned, Service Plan dated July 29, 2024, indicated he received services to including medication administration, behavior management, blood sugar checks, assistance with bathing, grooming, and toileting. R2's most recent assessment was requested. R2's comprehensive assessment dated March 14, 2024, was provided. R2's 90-day reassessment was due June 12, 2024. The licensee failed to complete a timely 90-day reassessment. On July 30, 2024, at 10:35 a.m. LALD/CNS-A stated R2 was hospitalized starting on June 30, 2024, and had not completed a 90-day reassessment when it was due in early June. Furthermore, LALD/CNS-A stated she was behind on completing R1 and R2's 90-day assessments. The licensee's Assessment and Reassessment of Residents policy dated July 2024, indicated resident reassessment and monitoring must be conducted no more than 14 calendar days after initiating services. On-going reassessment and monitoring will be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620			
01640 SS=F	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to	01640			

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01640	Continued From page 50 (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the service plan included a signature or other authentication by the resident and the facility to document agreement on the services provided 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).	01640			

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01640	Continued From page 51 The findings include: R1 R1 was admitted to the facility on October 25, 2018, and began receiving services under the licensee's assisted living license on August 1, 2021. On July 30, 2024, at 9:05 a.m. the surveyor observed registered nurse (RN)-B set up and administer R1's medications. R1's unsigned, Service Plan dated July 29, 2024, indicated R1 received services including medication administration, blood sugar checks, assistance with bathing, grooming, transfers, behavior management and vital signs. R1's Service Plan lacked a signature by the resident or resident representative or facility representative to document agreement on the services provided to R1. On July 29, 2024, at 2:20 p.m. licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated she had completed all three residents' Service Plans within the licensee's electronic medical record system; however she had not printed them, not signed them as the facility representative, nor had the residents/resident's representative sign them. The licensee's Service Plan policy dated July 2024, indicated the service plan and any revisions must include a signature or other authentication by the assisted living provider and by the resident or resident's representative documenting agreement on the services to be provided.	01640			

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01640	Continued From page 52 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01640			
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use	01730			

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01730	Continued From page 53 to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individualized medication management plan included all required content for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1's diagnoses included diabetes, depression, and alcohol abuse. R1's unsigned, Service Plan dated July 29, 2024, indicated R1 received services including medication administration, blood sugar checks, assistance with bathing, grooming, transfers, behavior management and vital signs. On July 30, 2024, at 9:05 a.m. the surveyor observed registered nurse (RN)-B set up and administered R1's medications.	01730			

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01730	Continued From page 54 R1's prescriber orders dated June 12, 2024, included one medication for the heart/blood thinner, one for agitation, one for depression, one for nerve pain, two for heartburn, one for acid reflux, one for constipation, two for mild pain/anti-inflammatory, one for bowel spasms, one oral medication for diabetes, one injection for diabetes, two topical antifungal, one topical medication for pain, one nasal spray for allergies, and four supplements. R1's medication plan found in R1's assessment dated May 8, 2024, in the section labeled Medication, lacked the required content to include medication tasks that may be delegated to unlicensed personnel. On July 30, 2024, at 1:15 p.m. licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated R1's medication plan did not include the medication tasks delegated to unlicensed personnel, and stated this option was not selected within the application used for developing any of the resident's medication plans. The licensee's Individualized Medication Management Plan and Record policy dated July 2024, indicated the licensee would develop a medication plan to include identification of medication management tasks that may be delegated to unlicensed personnel. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730			

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01880	Continued From page 55	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 ensure the licensee's mini-medication refrigerator maintained an acceptable temperature to ensure the medications were stored according to manufacturer's recommendations for two of two residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On July 29, 2024, at 11:30 a.m. during the entrance conference, licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated resident medications were stored in a locked medication closet in the lower level of the facility. Furthermore, she stated medications requiring refrigeration were securely stored in a mini-medication refrigerator in the lower level of the facility and had daily temperature monitoring.	01880			

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NAME OF PROVIDER OR SUPPLIER EDEN HOMES INC		STREET ADDRESS, CITY, STATE, ZIP CODE 7411 QUEEN AVENUE SOUTH RICHFIELD, MN 55423			
(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
01880	Continued From page 56 R1 R1's diagnoses included diabetes, depression, and alcohol abuse. R1's unsigned, Service Plan dated July 29, 2024, indicated R1 received services including medication administration. R1's Medication Management plan found in R1's assessment dated May 8, 2024, indicated her medications were kept in a double locked medication room in a designated cabinet. On July 30, 2024, at 9:05 a.m. registered nurse (RN)-B set up and administered R1's oral medication and assisted/monitored R1's self-administration of her Victoza insulin pen (for diabetes). R2 R2's diagnoses included diabetes, depression, and asthma. R2's unsigned, Service Plan dated July 29, 2024, indicated he received services including medication administration. R2's Medication Management Plan found in R2's assessment dated March 14, 2024, indicated his medications were kept in a locked room. On June 30, 2024, at 12:35 p.m. the surveyor and RN-B reviewed the licensee's medication storage closet and the mini-medication refrigerator. The mini-medication refrigerator included: - R1's Victoza insulin pen-13 pens-the package instructions indicated "Do not freeze." - R2's Victoza insulin pen-20 pens-the package instructions indicated "Do not freeze."	01880			

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01880	Continued From page 57 The mini-medication refrigerator had a thermometer placed inside and registered 40 degrees Fahrenheit. On top of the mini refrigerator was a black notebook designated to register the daily refrigerator temperature. Entries were noted to end in 2022, and restarted on the date survey started (July 29, 2024). The licensee failed to ensure R1 and R2's Victoza insulin pens were stored according to manufacturer's recommendations with no evidence of mini-medication refrigerator temperature monitoring. On June 30, 2024, at 12:45 p.m. RN-B stated she checked the mini-refrigerator daily but did not write the temperature in the book. She went on to state, "I know, if you don't write it, you didn't do it". Victoza Manufacturer's instructions for storage dated May 2011, indicated store your Victoza pen for 30 days either at 59°F to 86°F (15°C (Celsius) to 30°C), or in a refrigerator at 36°F to 46°F (2°C to 8°C). The licensee's Medication Management Services policy dated July 2024, indicated storing and securing medications - all resident medications will be stored in a locked compartment/cabinet or locked refrigerator at all times according to manufacturer's directions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880			
01890 SS=D	144G.71 Subd. 20 Prescription drugs	01890			

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01890	Continued From page 58 A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to label a time sensitive medication with an opened date for one of two residents (R2) and failed to ensure stored medications were not expired or included a proper label for two of three residents (R1, R2) with medication administration. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). MEDICATION OPEN DATES R2 R2's unsigned, Service Plan dated July 29, 2024, indicated R1 received services including medication administration. R2's signed prescriber's orders dated June 29, 2024, included an order for diclofenac gel 1% (topical medication for pain), give 2 grams (gm) three times daily as needed for joint pain.	01890			

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01890	Continued From page 59 On July 30, 2024, at 12:35 p.m. the surveyor and registered nurse (RN)-B reviewed the contents of the licensee's medication closet. R2's medication supply included two tubes of diclofenac gel. One tube (appeared to have been used) with a fill date of July 14, 2022, lacked an open date. RN-B stated she was not certain of the open date for the opened tube of diclofenac gel. EXPIRED MEDICATIONS/NO LABEL R1 R1's unsigned, Service Plan dated July 29, 2024, indicated R1 received services including medication administration, R1's signed prescriber's orders dated June 12, 2024, included acetaminophen 325 milligrams (mg) - give two tablets by mouth every six hours as needed for pain. On July 30, 2024, at 12:35 p.m. the surveyor and RN-B reviewed the contents of the licensee's medication closet. R1's medication drawer included a bottle of acetaminophen 325 mg in a prescription bottle with no indicated expiration date. The prescription label indicated a last fill date of July 28, 2021. Additionally, R1's medication drawer included an over-the-counter bottle of acetaminophen 325 mg without a proper label. R2 R2's signed provider orders dated June 19, 2024, included fluticasone 50 micrograms (mcg) spray, instill two sprays into each nostril daily. On July 30, 2024, at 12:35 p.m. the surveyor and RN-B reviewed the contents of the licensee's medication closet. R2's medication supply included a bottle of fluticasone nasal spray (for	01890			

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01890	Continued From page 60 allergies), 50 micrograms/spray, with an expiration date of March 8, 2024. Additionally, R2's medication supply included a tube of diclofenac gel that lacked a proper label. The licensee failed to ensure R1 and R2's medications had not exceeded the expiration date and include a proper label. On July 30, 2024, at 12:40 p.m. RN-B stated she regularly reviewed the medications in the medication closet for expiration dates and missed these noted medications. Furthermore, the unlabeled diclofenac gel was R2's and was uncertain why it lacked a label. The licensee's Medication Management Services policy dated July 2024, indicated the RN will ensure that all medications are properly labeled in clear, non-faded print, and that the label includes the medication expiration date. The RN will check for expired medications with every setup. The RN will also label time sensitive medications with the date medication was opened and the appropriate expiration date. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890			
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services	01940			

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01940	Continued From page 61 that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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	01940			

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01940	Continued From page 62 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on July 29, 2024, at 11:30 a.m. licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee provided treatment management services to residents, including blood sugar checks. R1's diagnoses included diabetes, depression, and alcohol abuse. R1's unsigned, Service Plan dated July 29, 2024, indicated R1 received services including medication and blood sugar checks. On July 30, 2024, registered nurse (RN)-B was observed to assist R1 with a blood sugar check. RN-B stated R1 was mostly independent with her blood sugar check but needed staff observation for the procedure, and to obtain the blood sugar results. R1's Task Record dated July 2024, included daily blood glucose readings. R1's assessment dated May 8, 2024, in the section identified as diabetes management, indicated R1 preferred to complete blood sugar checks herself but needed verbal reminders. R1's treatment record lacked the required content to include: - documentation of specific resident instructions relating to the treatments or therapy administration to include blood sugar parameters; and	01940			

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01940	Continued From page 63 - procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services On July 30, 2024, at 1:15 p.m. LALD/CNS-A stated R1's record lacked the information as listed above. The licensee's Treatment and Therapy Plan policy dated July 2024, indicated the Treatment Plan would include documentation of specific instructions that relate to providing the treatment or therapy administration. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940			
02240 SS=C	144G.90 Subdivision 1 Assisted living bill of rights; notification (a) An assisted living facility must provide the resident a written notice of the rights under section 144G.91 before the initiation of services to that resident. The facility shall make all reasonable efforts to provide notice of the rights to the resident in a language the resident can understand. (b) In addition to the text of the assisted living bill of rights in section 144G.91, the notice shall also contain the following statement describing how to file a complaint or report suspected abuse: "If you want to report suspected abuse, neglect, or financial exploitation, you may contact the Minnesota Adult Abuse Reporting Center (MAARC). If you have a complaint about the facility or person providing your services, you may	02240			

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02240	Continued From page 64 contact the Office of Health Facility Complaints, Minnesota Department of Health. If you would like to request advocacy services, you may contact the Office of Ombudsman for Long-Term Care or the Office of Ombudsman for Mental Health and Developmental Disabilities." (c) The statement must include contact information for the Minnesota Adult Abuse Reporting Center and the telephone number, website address, email address, mailing address, and street address of the Office of Health Facility Complaints at the Minnesota Department of Health, the Office of Ombudsman for Long-Term Care, and the Office of Ombudsman for Mental Health and Developmental Disabilities. The statement must include the facility's name, address, email, telephone number, and name or title of the person at the facility to whom problems or complaints may be directed. It must also include a statement that the facility will not retaliate because of a complaint. (d) A facility must obtain written acknowledgment from the resident of the resident's receipt of the assisted living bill of rights or shall document why an acknowledgment cannot be obtained. Acknowledgment of receipt shall be retained in the resident's record. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the current Minnesota Bill of Rights (BOR) for Assisted Living Residents, and a written acknowledgement was received 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	02240			

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02240	Continued From page 65 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: R1 began receiving assisted living services on August 1, 2021. R1's record included a copy of the BOR dated May 16, 2021; however, R1's record lacked evidence the most updated version of the BOR dated November 2022, was received. On July 30, 2024, at 10:45 a.m. licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated none of the current residents had received the most recent version (dated November 2022) BOR. The licensee's Assisted Living Bill of Rights policy dated July 2024, indicated the Assisted Living Bill of Rights shall be redistributed to residents following any revisions or modifications. A signed copy of the Assisted Living Bill of Rights will be maintained in the clinical record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02240			
02310 SS=F	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date	02310			

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02310	Continued From page 66 service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the care and services were provided according to acceptable health care and medical, or nursing standards for two residents (R1, R2) with bed rails. 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 R1's diagnoses included diabetes, depression, and alcohol abuse. R1's unsigned, Service Plan dated July 29, 2024, indicated R1 received services including medication administration, blood sugar checks, assistance with bathing, grooming, transfers, behavior management and vital signs. On July 29, 2024, at 12:40 p.m. the surveyor noted R1's room to include a consumer bed rail on the right side of R1's bed. The bed rail included three horizontal bars with openings enclosed by a canvas like wrap. The bed rail was securely fastened to the bed. R1 was in bed and stated she actively used the bed rail system to help her get in and out of bed, and with	02310			

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02310	Continued From page 67 repositioning while in bed. R1's record included the manufacturer's instructions for the bed rail system and a comprehensive assessment dated May 8, 2024. Within the assessment under the section bed safety, the partial bed rails were identified for safety due to R1's history of falls. The licensee failed to complete a comprehensive assessment of R1's bed rail use to include R1's individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. In addition, R1's record lacked evidence of education to the resident regarding the risks verses benefits of bed rail use, or evidence the licensee checked for safety recalls of the bed rail system. R2 R2's diagnoses included diabetes, depression, and asthma. R2's unsigned, Service Plan dated July 29, 2024, indicated he received services to including medication administration, behavior management, blood sugar checks, assistance with bathing, grooming, and toileting. On July 29, 2024, at 12:45 p.m. the surveyor observed R2's hospital bed with upper half bed rails in the upright position on both sides of the bed. The bed rails included seven vertical bars and were securely fastened to the bed. Licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated R2 was currently hospitalized and was not expected to return for a few more weeks. R2's record included a comprehensive nurse	02310			

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02310	Continued From page 68 assessment dated March 14, 2024, and included a section labeled bed safety and indicated side rails in use, partial side rail. The assessment indicated the measurements of bed rail zones 1-4 met FDA guidelines; however, the licensee failed to complete a comprehensive assessment of R2's bed rail use to include R2's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. In addition, R2's record lacked evidence of education to the resident regarding the risks verses benefits of bed rail use. On July 29, 2024, at 2:20 p.m. LALD/CNS-A indicated she had completed hospital bed rail measurements and some of the bed rail assessment information; however, she was not aware of the required elements of a comprehensive bed rail assessment, the requirement to review risks verses benefits with the residents using bed rail systems, nor the requirement to check for recalls for consumer bed rail systems. The licensee's Use of Bed Rails policy dated 2021, indicated side rails will not be used in the assisted living setting except in situations where assessment determines they are necessary for safety of the resident. If the resident or resident's representative wants side rails on the bed, facility RN will educate the resident/representative about the risks related to side rails and will assess whether the side rails meet FDA standards. When notified that a resident has a side rail or that the resident or their representative is requesting side rails, the RN will assess and evaluate what the resident's needs are and if the resident can safely utilize the side rail/equipment. Assessment will	02310			

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02310	Continued From page 69 determine whether the equipment meets the FDA standards for side rails. The RN will document the teaching provided regarding the risks of using side rails. Documentation will include family members or resident's representative who received the education on the safe use of side rails. The March 10, 2006, FDA Side Rail Entrapment Zones and Dimensional Recommendations indicated to reduce the risk of entrapment, zone 1 (space between the rails), zone 2 (space under the rail, between the rail supports) zone 3 (space between the rail and mattress), should be less than 4 and 3/4 inches. Zone 4 (space under the rail at the ends of the rail, between the rail and mattress) should be less than 2 and 3/8 inches. The FDA, "A Guide to Bed Safety" revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe". The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently Asked Questions (FAQs) indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high	02310			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33757	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/31/2024
NAME OF PROVIDER OR SUPPLIER EDEN HOMES INC		STREET ADDRESS, CITY, STATE, ZIP CODE 7411 QUEEN AVENUE SOUTH RICHFIELD, MN 55423			
(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
02310	Continued From page 70 risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, "Documentation about a resident's bed rails includes, but is not limited to: - Purpose and intention of the bed rail; - Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail; - The resident's bed rail use/need assessment; - Risk vs. benefits discussion (individualized to each resident's risks); - The resident's preferences; - Installation and use according to manufacturer's guidelines; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements". Additionally, the MDH website indicated for hospital-style bed rails, the licensee must include in their documentation, the bed rail measurements and that the bed rail has not shifted and is securely attached to the bed frame per manufacturer recommendations. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE On July 30, 2024, the immediacy was removed; however, non-compliance remains at a scope and level of F.	02310			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33757	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/31/2024
NAME OF PROVIDER OR SUPPLIER EDEN HOMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 7411 QUEEN AVENUE SOUTH RICHFIELD, MN 55423		
(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
03090	Continued From page 71	03090			
03090 SS=C	144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure signage was posted at the main entry of the building of the establishment to display statutory language to disclose electronic monitoring activity, potentially affecting all three residents, staff, and visitors of the licensee. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: Upon entrance to the facility on July 29, 2024, at 11:00 a.m. the surveyor observed the front entrance and entryway of the facility. No electronic monitoring signage was observed. On July 29, 2024, at 11:35 a.m. licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated they did not have electronic	03090			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33757	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/31/2024
NAME OF PROVIDER OR SUPPLIER EDEN HOMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 7411 QUEEN AVENUE SOUTH RICHFIELD, MN 55423		
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03090	Continued From page 72 monitoring in place at this time and there was no sign displayed in statutory language to disclose possible electronic monitoring activity. LALD/CNS-A stated he was not aware of the regulation for this posting. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	03090			



Minnesota Department Of Health
Food, Pools, and Lodging Services
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: 07/29/24
Time: 10:30:40
Report: 1050241130

Food and Beverage Establishment Inspection Report

Page 1

Location:

Eden Homes Inc
7411 Queen Avenue South
Richfield, MN55423
Hennepin County, 27

Establishment Info:

ID #: 0038166
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6122454140
ID #:

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

The following orders were issued during this inspection.

2-100 Supervision

2-102.12AMN

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

FACILITY DOES NOT HAVE A CURRENT MN CFPM CERTIFICATION ON SITE. DISCUSSED REQUIREMENTS MDH INSTRUCTIONS AND FACT SHEETS PROVIDED VIA EMAIL. COMPLY WITH RULE ABOVE.

Comply By: 09/01/24

4-600 Cleaning Equipment and Utensils

4-602.12

MN Rule 4626.0850 Clean the food contact surfaces of cooking and baking equipment and interior cavities of microwave ovens at least every 24 hours.

OBSERVED INTERIOR OF MICROWAVE HAS SPLATTERS AND/OR FOOD DEBRIS. DISCUSSED CLEANING AND MAINTAINING BY ESTABLISHING A CLEANING FREQUENCY TO AVOID BUILD UP. COMPLY WITH RULE ABOVE.

Comply By: 07/30/24

Surface and Equipment Sanitizers

Hot Water: = at 160F Degrees Fahrenheit

Location: DISH WASHER

Violation Issued: No

Food and Equipment Temperatures

Type: Full
Date: 07/29/24
Time: 10:30:40
Report: 1050241130
Eden Homes Inc

Food and Beverage Establishment Inspection Report

Page 2

Process/Item: Cold Holding/MILK
Temperature: 38F Degrees Fahrenheit - Location: REACH IN COOLER
Violation Issued: No

Process/Item: Cold Holding/ NOODLES
Temperature: 38F Degrees Fahrenheit - Location: REACH IN COOLER
Violation Issued: No

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

Announced inspection completed 7/29/24 with MDH Andrew Spaulding and Owner Aileen. Deb Jacobson was the lead Health Regulation Division Nurse Evaluator. Facility had three residents on site at time of inspection. Meals are prepared on site.

This establishment has a residential kitchen. Food is prepared for same day service if leftovers kept no longer than 2 days. The kitchen has wood cabinets with a hollow base and wooden flooring, popcorn ceiling. All found to be in good condition.

Discussed the following:

- Employee illness policy and logging requirements
- Handwashing
- Glove-use and bare hand contact
- Food storage and preventing cross contamination
- Date marking
- Vomit clean up procedures
- Restrictions concerning serving a highly susceptible population

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 1050241130 of 07/29/24.

Certified Food Protection Manager: _____

Certification Number: _____ Expires: ____ / ____ / ____

Inspection report reviewed with person in charge and emailed.

Signed: _____

Aileen R. Villanueva
Owner

Signed: _____

Andrew Spaulding
Public Health Sanitarian 2
FPLS Metro
651-201-5298
andrew.spaulding@state.mn.us