Electronically Delivered

November 8, 2024

Licensee
The Geneva Suites
9145 Meadowview Road
Bloomington, MN 55425

RE: Project Number(s) SL32258015

Dear Licensee:

On October 8, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the August 19, 2024, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

Tim Hanna, Supervisor
State Engineering Services Section
Email: Tim.Hanna@state.mn.us
Telephone: 507-208-8982 Fax: 1-866-890-9290

HHH

Electronically Delivered

August 22, 2024

Licensee
The Geneva Suites
9145 Meadowview Road
Bloomington, MN 55425

RE: Project Number(s) SL32258015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 18, 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 . . ."

IMPOSITION OF FINES

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

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

In accordance with Minn. Stat. § 144G.31, Subd. 4(a)(5), MDH may impose fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. MDH may impose a fine of $1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. MDH also may impose a

fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

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

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

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00
St - 0 - 0820 - 144g.45 Subd. 2 (g) - Fire Protection And Physical Environment - $3,000.00

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

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS
In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by 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

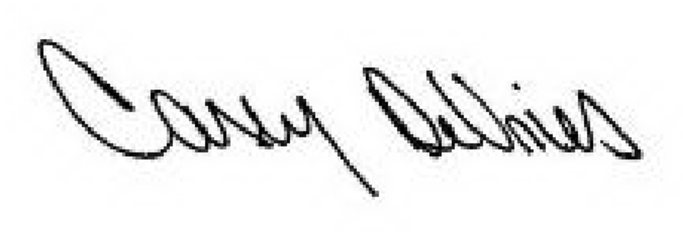
To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms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

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,



Casey DeVries, Supervisor
State Evaluation Team
Email: Casey.DeVries@state.mn.us
Telephone: 651-201-5917 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32258	A. BUILDING: _____ B. WING _____	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GENEVA SUITES	9145 MEADOWVIEW ROAD BLOOMINGTON, MN 55425

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL32258015-0 On July 15, 2024, through, July 18, 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 six residents; six receiving services under the provider's Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living 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.	
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and	0 510		

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0 510	Continued From page 1 maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an effective infection control program to comply with accepted health care, medical, and nursing standards for infection control. This practice had the potential to affect the licensee's residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: HAND HYGIENE/DISINFECTION On July 16, 2024, at 7:10 a.m., the surveyor observed unlicensed personnel (ULP)-F performing morning cares on R2. ULP-F entered R2's room, performed hand hygiene and put	0 510		

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0 510	Continued From page 2 gloves on. R2 was sitting upright at the edge of the bed. ULP-F moved R2's walker in front of R2 and instructed them to stand. ULP-F stated they were going to change their adult brief. ULP-F unfastened the adult brief and placed it directly on the floor. The adult brief had discoloration to the front which indicated it had been soiled. ULP-F then applied a clean adult brief onto R2 and finished dressing R2. On July 16, 2024, at 7:23 a.m., the surveyor observed ULP-F escort R2 from the bedroom to the communal bathroom across the hallway wearing the same pair of gloves from cares performed in R2's bedroom. In the bathroom ULP-F removed the gloves and placed a new pair of gloves on. ULP-F used a washcloth on R2's face. ULP-F instructed R2 to wash their hands. ULP-F did not perform hand hygiene in between glove changes. On July 16, 2024, at 7:30 a.m., without performing hand hygiene before leaving the bathroom, ULP-F removed gloves and escorted R2 out of the bathroom, along the hallway to the dining area. On July 16, 2024, at 7:33 a.m., the surveyor observed ULF-F walk from the dining area to the adjoining kitchen where they washed their hands in the kitchen sink. On July 16, 2024, at 7:34 a.m., ULP-F returned to R2's bedroom, applied gloves, removed the bedsheet and under pad from R2's bed and placed the linen into the clothes hamper. ULP-F obtained a new bedsheet from the closet and applied the new sheet to the bed. At 7:39 a.m., ULP-F picked up the adult brief from the floor and placed it into a trash can. ULP-F took the trash	0 510		

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0 510	Continued From page 3 can bag, placed a new trash bag into the trash can, then walked out of the room to the garage area and disposed of the trash bag into a larger trash container. On July 16, 2024, at 7:43 a.m., ULF-F stated they were trained to perform hand hygiene between glove removal or glove changes. ULP-F stated they were forgot to perform hand hygiene. On July 16, 2024, at 10:27 a.m., clinical nurse supervisor/director of nursing (CNS/DON)-C stated staff members were trained to perform hand hygiene before and after glove removal. CNS/DON-C stated they were unsure why ULP-F did not perform hand hygiene between glove changes. SHARED MEDICAL EQUIPMENT On July 17, 2024, at 8:36 a.m., in the front common area of the upper part of the split-level home, the surveyor observed R1 sitting in an armchair. ULF-G applied a blood pressure cuff to R1's left wrist and recorded the blood pressure reading. ULP-G applied the same blood pressure cuff to R1's right wrist and recorded the blood pressure. ULP-G removed the cuff, walked to a shelving unit close to the front door, and placed the blood pressure cuff into a fabric basket. ULP-G failed to disinfect (clean) the blood pressure cuff after use on R1. On July 17, 2024, at 9:04 a.m., ULP-G stated the blood pressure cuff was used on all residents and they were not trained by the registered nurse (RN) to disinfect the blood pressure cuff after each use. On July 17, 2024, at 9:50 a.m., CNS/DON-C	0 510		

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0 510	Continued From page 4 stated the blood pressure cuff was used for all residents, and ULP's were trained to disinfect the blood pressure cuff after use. The licensee's 8.01 Infection Control policy dated June 17, 2024, indicated [licensee] infection control policy would be consistent with current guidelines from Center of Disease Control (CDC). The licensee's 8.03 Cleaning of Shared Medical Equipment policy June 17, 2024, indicated [licensee] would implement and maintain a process to ensure all reusable resident care equipment is routinely cleaned, and when appropriate, disinfect before and after reuse. The Center for Disease Control (CDC) Disinfection of Healthcare Equipment guidance, dated November 23, 2023, indicated it was a requirement to clean equipment with appropriate disinfectant after contact with a blood or other potentially infectious materials. In addition, medical equipment surfaces should be disinfected with an environmental protection agency (EPA) registered low or intermediate level disinfectant. The CDC Hand Hygiene for Healthcare Workers dated February 27, 2024, indicated hand hygiene should be performed prior to placing gloves on, removing gloves, and before exiting a patient room. No other information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		

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0 550	Continued From page 5	0 550		
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 required information related to the licensee's grievance procedure to include contact information for the Office of Ombudsman for Long-Term Care (OOLTC) and Mental Health and Developmental Disabilities (OOMHDD). 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 client's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect	0 550		

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0 550	Continued From page 6 a large portion or all of the residents). The findings include: On July 15, 2024, at 10:32 a.m., during a facility tour, the surveyor observed no evidence of the contact information for the state and applicable regional OOLTC and OOMHDD. On July 15, 2024, at 12:20 p.m., the surveyor enquired to operations director (OD)-A where the required OOTLC and OOMHDD postings were located in the facility. OD-A stated they believed the contact information was included in the Minnesota Adult Abuse Reporting Center (MAARC) posting that was displayed in the facility and it was an honest mistake for not having the contact information available. The licensee's 2.10 Complaint/Grievance Posting policy dated May 6, 2024, indicated [licensee] was required to post contact information for OOTLC and OOMHDD in a conspicuous place. No other information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility;	0 640		

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0 640	Continued From page 7 (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post the 911 emergency number in common areas and near telephones provided by the assisted living facility. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a 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 15, 2024, at 10:32 a.m., during a facility tour of the split-level home, in the upper part of the home, the surveyor observed a landline telephone in the kitchen area. There was no 911 posting near the landline telephone. On July 15, 2024, at 11:32 a.m., unlicensed personnel (ULP)-H stated the landline telephone was used by residents and not staff. On July 15, 2024, at 12:20 p.m., operations director (OD)-A stated they were aware of the required 911 signage and was unsure sure why it	0 640		

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0 640	Continued From page 8 was no longer near the landline telephone. On July 17, 2024, at 8:16 a.m., the surveyor observed R3 use the landline telephone to make a telephone call. No other information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 640		
0 650 SS=E	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced	0 650		

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0 650	Continued From page 9 by: Based on observation, interview, and record review, the licensee failed to ensure employee records included all required content for two of three employees (unlicensed personnel (ULP)-F, ULP-G) 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: ULP-F ULP-F's employee file included [licensee] Offer of Employment signed by ULP-F June 16, 2019, to provide direct care services. On July 15, 2024, at 7:10 a.m., the surveyor observed ULP-F performing morning cares on R2. ULP-F's employee file lacked the following content: -annual performance reviews; and -competency evaluations: -administering medications or treatments as required. ULP-G The licensee's Employee List indicated ULP-G was hired August 28, 2023, to provide direct care services.	0 650		

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0 650	Continued From page 10 ULP-G employee file lacked the following content: -copy of Nurse Aid Certificate. On July 17, 2024, at 10:17 a.m., the surveyor observed the Minnesota Nurse Aid Registry website which indicated ULP-G had a Minnesota Nurse Aid certificate that expired June 20, 2026. On July 18, 2024, at 8:43 a.m., ULP-F stated they were trained by the registered nurse (RN) to administer medications. ULP-F stated the RN observed them administrating medication to residents as part of the training. On July 18, 2024, at 8:59 a.m., clinical nurse supervisor/director of nursing (CNS/DON)-C stated they observed ULPs perform medication administration to residents then sign documentation as evidence ULPs are competent to administer medications independently. CNS/DON-C stated they were unsure why the documentation could not be located. On July 18, 2024, at 9:22 a.m., licensed assisted living director/owner (LALD/O)-D stated they were unaware a copy of the certificate should be included in the employee record. LALD/O-D stated they believed the performance reviews had been completed by the previous Director of Nursing (DON). LALD/O-D stated [licensee] hired a new Human Resources Director to ensure employee files were made compliant. The licensee's 4.05 Employee Records policy dated June 17, 2024, indicated employee files would contain current licensure, registration, or certificates. The licensee's 6.17 Supervision of Staff -	0 650		

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0 650	Continued From page 11 Delegated Services dated May 2, 2024, indicated staff members would be observed performing medication and treatment administration and documentation would be retained in the employee's record. No other information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule.	0 680		

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0 680	Continued From page 12 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a written emergency preparedness (EP) plan with all the required content as defined in Appendix Z. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's emergency disaster preparedness plan dated June 7, 2024, lacked evidence of the following required content: - process for cooperation and collaboration with local, tribal, regional, State and Federal EP to maintain integrated response; - name and location of facility receiving relocated residents; - safe evacuation from the facility, including consideration of care/tx needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); primary/alternate communication means with external sources of assistance; - policies and procedures for medication documentation that preserves resident information; protects confidentiality, and secures and maintains availability of records;	0 680		

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0 680	Continued From page 13 - policies and procedures for volunteers; - transportation plan for transportation of residents; - roles under a waiver declared by secretary; - emergency official contact information; - primary and alternative means for communication; - methods for sharing information; - long-term care (LTC) family notifications, and; - emergency preparation and testing requirements. On July 16, 2024, at 1:15 p.m., licensed assisted living director (LALD)-D stated the EP plan was accessible through Share Point (online cloud space website), and a hardcopy should be posted in the facility. LALD-D stated the EP plan was not posted in the facility as they were in the process of correcting the EP plan. LALD-D stated they were aware the EP plan had missing content did not meet the 144G requirements. The licensee's 9.01 Emergency Preparedness Plan -Appendix Z Compliance policy dated June 17, 2024, indicated [license] would have an effective and compliant emergency preparedness plan. No other information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and:	0 780		

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0 780	Continued From page 14 (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to 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	0 780		

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0 780	Continued From page 15 a large portion or all of the residents). The findings include: On July 17, 2024, at 10:00 a.m., survey staff toured the facility with operation director (OD)-B. During the facility tour, it was observed that the sleeping rooms were equipped with smoke alarms. However, upon testing, resident sleeping rooms 1, 2, and 3 on the main level were not interconnected and the actuation of one alarm would not cause all alarms to operate. During the interview on July 17, 2024, at 10:30 a.m., OD-B stated the smoke alarms in three bedrooms on the main level 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		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment in a continuous state of good repair and operation	0 800		

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0 800	Continued From page 16 with regard to the health, safety, and well-being of the residents. This had the potential to directly affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On July 17, 2024, at 10:00 a.m., survey staff toured the facility with operation director (OD)-B. During the facility tour, survey staff observed the following items: In the staff room on the lower level, it was observed there were brown stains on the acoustical ceiling tile with evidence of water leakage from above the ceiling. It was also observed that inside of recessed light fixture was stained with evidence of water leakage. In the Bathroom on the lower level, brown stains were observed on the sheetrock ceiling, evidence of water leakage from above. In the Bathroom on the lower level, it was also observed that there was water pooled on the tile floor due to water draining from the adjacent roll-in shower. OB-D stated that the shower drain was installed too high, and the drain slope in the roll-in shower was not steep enough to allow water to flow to the shower drain. OB- D acknowledged that wet tile floors could be a slipping and falling hazard for residents.	0 800		

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0 800	Continued From page 17 During the facility tour on July 17, 2024, at 10:30 a.m., OD-B visually verified this deficient finding at the time of discovery. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one	0 810		

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0 810	Continued From page 18 evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on the interview and record review, the licensee failed to develop a fire safety and evacuation plan with the required elements and failed to provide required employee training on fire safety and evacuation as required. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: An interview and record review were conducted on July 17, 2024, at 11:00 a.m. with operation director (OD)-B on the fire safety and evacuation plan, fire safety and evacuation training for the facility, and fire safety and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The FSEP included standard employee actions to be taken but failed to provide specific procedures for employees to evacuate residents based on the facility's specific layout in the event of a fire or	0 810		

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0 810	Continued From page 19 similar emergency. The FSEP included standard resident evacuation procedures but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan failed to include ways to move, evacuate residents based on the facility's specific layout in the event of a fire or similar emergency. 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 17, 2024, at 11:30 a.m., OD-B stated that the policy was a basic policy from a third-party provider and had yet to be edited or updated to fit the facility. OD-B verified that the fire safety and evacuation plan for the facility lacked these provisions. TRAINING Record review of the available documentation indicated employees did not receive training twice per year after initial hire. Record review of the available documentation indicated the facility did not provide annual evacuation training for resident who are capable of assisting in their own evacuation. During the interview on July 17, 2024, at 11:30 a.m., OD-B confirmed that the facility provided only one fire safety training for employees when hired and verified the facility did not offer any FSEP training for the residents who are capable of assisting in their own evacuation.	0 810		

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0 810	Continued From page 20 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. The surveyor requested the fire drill record, and no documentation was provided by OD-B after the request. During the interview on July 17, 2024, at 11:30 a.m., OD-B stated that the licensee discussed the fire drill procedure in quarterly staff meetings, but he could not find any recorded documentation. OD-B verified this deficient finding. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 820 SS=G	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by:	0 820		

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0 820	Continued From page 21 Based on observation and interview, the licensee failed to provide facilities that were not a distinct hazard to life. The licensee had lock hardware that required a key to exit the home on the egress side of the front door. This had the potential to affect all occupied residents, staff, and visitors because timely evacuation would not be possible in the event of a fire or other life-threatening emergencies. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On July 17, 2024, at 10:00 a.m., survey staff toured the facility with operation director (OD)-B. During the facility tour, survey staff observed the following items: It was observed that the exit door in resident sleeping room 1 on the main level was locked with a keypad that required a code to open it. Survey staff verified with OD-B that the lock was not tied to the building fire alarm system and would not default to an unlocked (fail-safe) position if the power went out. It was also observed that the raised wood deck outside the egress door was enclosed with rails and did not have a proper way to exit the room. During the interview on July 17, 2024, at 10:30 a.m., survey staff explained to OD-B that the door	0 820		

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0 820	Continued From page 22 requiring a code to exit constituted an obstruction of egress and a distinct hazard to life. OD-B stated he understood the deficiency and would get the lock removed when the building maintenance person was available. A stair exit gate on the main level, it was observed that a wood block door stopper was installed on the head, and the wood block prevented the gate from opening. It was also observed that a padlock was installed at the jamb. During the interview on July 9, 2024, at 10:30 a.m., survey staff explained to OD-B that the lock in the path of egress would cause a delay in the proper exiting of the space during a fire or similar emergency. OD-B stated he understood the deficiency. TIME PERIOD FOR CORRECTION: Two (2) days	0 820		
0 830 SS=F	144G.45 Subd. 3 Local laws apply Assisted living facilities shall comply with all applicable state and local governing laws, regulations, standards, ordinances, and codes for fire safety, building, and zoning requirements. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to follow applicable state and local laws, regulations, standards, ordinances, and codes related to smoking for one of six residents (R3).	0 830		

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0 830	Continued From page 23 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On July 15, 2024, at 10:38 a.m., during a tour of the assisted living facility which was a split-level home, the surveyor observed the upper level had three bedrooms and the lower level had four bedrooms. The lower level included a common area, a conference room area, and a bathroom. R3's bedroom was located in the lower level of the house. R3 was admitted to the facility on April 25, 2024, and began receiving assisted living services. R3's diagnoses included left side hemiplegia (paralysis of the left side), major depressive disorder, chronic pain syndrome, hypertension, dysphagia (difficultly speaking), heart failure, chronic obstructive pulmonary disease (lung disease), sleep disorder, mild cognitive impairment, and chronic kidney disease (kidney failure). R3's service plan dated July 15, 2024, indicated R3 received assistance with bathing, dressing, grooming, nail care, vital sign monitoring, housekeeping, laundry, safety check, and toileting. On July 17, 2024, at 10:45 a.m., the engineering surveyor observed a white mist with a fruit type	0 830		

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0 830	Continued From page 24 odor in R3's bedroom. R3 stated to the engineering surveyor staff they had just vaped inside the bedroom. On July 17, 2024, at 11:14 a.m., operations director (OD)-B stated that staff have had several conversations with R3 that the facility was non-smoking. On July 17, 2024, at 11:15 a.m., clinical nurse supervisor/director of nursing (CNS/DON)-C made an entry to R3's progress note that indicated R3 was educated the facility was a non-smoking. R3's progress notes dated April 25, 2024, through July 16, 2024, lacked documentation of education provided to R3 related to no smoking in the facility. CNS/DON-C stated the education should had been documented, and the smoking policy was given to residents upon admission. On July 17, 2024, at 11:17 a.m., R3 stated they were not aware the facility was a non-smoking facility and had vaped previously in the bedroom. During the conversation with R3, CNS/DON-C stated to R3 the facility was non-smoking or vaping. On July 17, 2024, at 11:42 a.m., R3 showed the surveyor a red package, "Whole Melt Extract Live Diamond Vaporizer." R3 stated it was the product they used to vape in the bedroom. On July 17, 2024, at 12:30 p.m., licensed assisted living director/owner (LALD/O)-D stated residents were allowed to vape inside their bedrooms if there was a medical doctor's order. LALD/O-D stated were not aware R3 was vaping inside the facility. LALD/O-D stated they were not aware of the Minnesota Department of Health's	0 830		

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0 830	Continued From page 25 Minnesota Clean Indoor Air Act (MCIAA). On July 17, 2024, at 12:38 p.m., CNS/DON-C stated an order from a medical doctor would not exist for allowing residents to vape inside the facility. The licensee's Smoking Policy dated June 29, 2024, indicated the assisted living facility (ALF) was a smoke free facility and that smoking was only permitted outside the home. The Minnesota Department of Health's Minnesota Clean Indoor Air Act (MCIAA) amendment effective on August 1, 2019, noted smoking was prohibited in health care facilities and clinics. In addition, an indoor area meant a space between a floor and a ceiling that is at least half enclosed by walls, doorways, or windows (opened or closed) around the perimeter. A wall included retractable dividers, garage doors, plastic sheeting or any other temporary or permanent physical barrier. MCIAA defined smoking to include: carrying or using an activated electronic delivery device. Minnesota State Statute 144.414 Prohibitions; Subdivision 3 dated 2022, indicated under a section titled Health care facilities and clinics. (a) Smoking is prohibited in any area of a hospital, health care clinic, doctor's office, licensed residential facility for children, or other health care-related facility, except that a patient or resident in a nursing home, boarding care facility, or licensed residential facility for adults may smoke in a designated separate, enclosed room maintained in accordance with applicable state and federal laws. No further information was provided.	0 830		

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0 830	Continued From page 26 TIME PERIOD FOR CORRECTION: Two (2) days	0 830		
0 950 SS=C	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by:	0 950		

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0 950	Continued From page 27 Based on interview and record review, the licensee failed to offer the resident the opportunity to identify a designated representative in writing with the required statutory language for four of four residents (R1, R2, R3, and R4). 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 of the residents). The findings include: R1 was admitted to the facility on June 10, 2021, and began receiving assisted living services. R2 was admitted to the facility on January 15, 2020, under the licensee's former comprehensive license and began receiving assisted living services on August 1, 2021. R3 was admitted to the facility on April 25, 2024, and began receiving assisted living services. R4 was admitted to the facility on June 18, 2024, and began receiving assisted living services. R1, R2, R3 and R4's Assisted Living Contract lacked the required verbatim language for designating a representative. On July 16, 2024, at 1:15 p.m., licensed assisted living director/owner (LALD/O)-D stated residents were allowed to designate a representative but was not aware of the verbatim language requirement. LALD/O-D stated the Assisted Living	0 950		

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0 950	Continued From page 28 Contracts for R1 and R2 contained a signature page to designate a representative but did not include the verbatim language. LALD/O-D stated a lawyer had created the new Assisted Living Contract and was unsure why the included language was not verbatim for R3 and R4's contract. The licensee's 1.08 Designated Representative policy dated June 19, 2024, indicated the following language should be included in the Assisted Living Contract, "You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." No other information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 950		
0 970 SS=B	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law.	0 970		

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0 970	Continued From page 29 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the licensee's liability for health, safety, or personal property of a resident for two of six residents (R1, R3). 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 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: R1 R1 was admitted to the facility on June 10, 2021, and began receiving assisted living services. R1's [licensee] House Services Contract and Lease Agreement dated May 27, 2020, page eight, section number 25 included the following statement, "Landlord is not liable to Tenant or Tenant's guests for any injury, death or property damage occurring in the Residential Unit or on Landlord's premises unless such injury, death or property damage occurs as the result of an equipment malfunction or hazardous conditions within the building not ca used by Tenant or Tenant's guests. Landlord is also not liable for any injury, death or da mage occurring as the result of Tenant's receipt of health-related, supportive or other services from third party providers. Landlord	0 970		

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0 970	Continued From page 30 may be liable to Tenant for its own negligent acts or those of its employees or agents. Unless caused by one of the aforementioned excepted reasons, Tenant agrees to hold Landlord harmless from any and all claims for injuries, property damage or any other loss resulting from an accident or other occurrence in the Residential Unit or on Landlord's premises". R3 R3 was admitted to the facility on April 25, 2024, and began receiving assisted living services. R3's [licensee] House Services Contract and Lease Agreement dated April 9, 2024, page eight, section number 25 included the following statement, "Landlord is not liable to Tenant or Tenant's guests for any injury, death or property damage occurring in the Residential Unit or on Landlord's premises unless such injury, death or property damage occurs as the result of an equipment malfunction or hazardous conditions within the building not ca used by Tenant or Tenant's guests. Landlord is also not liable for any injury, death or da mage occurring as the result of Tenant's receipt of health-related, supportive or other services from third party providers. Landlord may be liable to Tenant for its own negligent acts or those of its employees or agents. Unless caused by one of the aforementioned excepted reasons, Tenant agrees to hold Landlord harmless from any and all claims for injuries, property damage or any other loss resulting from an accident or other occurrence in the Residential Unit or on Landlord's premises". On July 18, 2024, at 9:22 a.m., licensed assisted living director (LALD)-D stated they were aware the contract could not contain a liability clause and they were working to have residents sign a	0 970		

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0 970	Continued From page 31 new contract without the liability clause. No other information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
01290 SS=F	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a background study was submitted and a clearance received in affiliation with the assisted living licensee's current health facility identification (HFID) for one of three employees (unlicensed personnel (ULP)-F). 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	01290		

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01290	Continued From page 32 resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-F's employee file included [licensee] Offer of Employment signed by ULP-F June 16, 2019, to provide direct care services. ULP-F's employee file included a background study clearance dated September 22, 2019, which was affiliated with the licensee's sister facility (HFID) # 32475. The licensee failed to have a background study clearance for ULP-F affiliated with HFID 32258. On July 16, 2024, at 1:24 p.m., licensed assisted living director (LALD)-D stated each staff member was required to have a completed background study affiliated with each facility HFID. LALD-D requested to the surveyor the conversation end as they had a situation to address. The phone call ended. On July 17, 2024, at 7:10 a.m., the surveyor observed ULP-F providing direct care services to R2. On July 17, 2024, at 9:10 a.m., LALD-D stated they were made aware each staff member was required to have a background check affiliated with each assisted living facility (ALF) from a previous Minnesota Department of Health (MHD) survey. LALD-D stated they were working on compliance for all [licensee] facilities. LALD-D stated they had not had enough time to bring each facility into compliance.	01290		

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01290	Continued From page 33 The licensee's 4.02 Background Studies policy dated June 17, 2024, indicated [licensee] would conduct a Minnesota Department of Human Services Background Study on all employees and volunteers, and contractors at [licensee]. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01370 SS=D	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating;	01370		

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01370	Continued From page 34 (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and competency evaluations were completed for all required skill areas, prior to providing services, for one of three employees (unlicensed personnel (ULP)-F). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-F's employee file included [licensee] Offer of Employment signed by ULP-F June 16, 2019, to provide direct care services.	01370		

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01370	Continued From page 35 ULP-F's employee record lacked evidence of the following training: -awareness of confidentiality and privacy. On July 15, 2024, at 7:10 a.m., the surveyor observed ULP-F performing morning cares on R2. On July 18, 2024, at 9:22 a.m., licensed assisted living director/owner (LALD/O)-C stated [licensee] changed to Relias (software training program) to train staff and it was an oversight for not ensuring staff had completed the required training. The licensee's 5.01 Orientation of Staff and Supervisors & Content policy dated May 31, 2024, indicated evidence of required orientation topics must be kept in the employee's record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		
01380 SS=D	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive,	01380		

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01380	Continued From page 36 and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and competency evaluations were completed for all required skill areas, prior to providing services, for one of three staff members (unlicensed personnel (ULP)-F). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-F's employee file included [licensee] Offer of Employment signed by ULP-F June 16, 2019, to provide direct care services. ULP-F's employee record lacked documentation of signed training and competencies by the registered nurse (RN) for: Training: -recognizing physical, emotional, cognitive, and developmental needs of the resident. Competency evaluations: -administering medications or treatments as	01380		

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01380	Continued From page 37 required. On July 15, 2024, at 7:10 a.m., the surveyor observed ULP-F performing morning cares on R2. On July 18, 2024, at 8:43 a.m., ULP-F stated they were trained by the registered nurse (RN) to administer medications. ULP-F stated the RN observed them administrating medication to residents as part of the training. On July 18, 2024, at 8:59 a.m., clinical nurse supervisor/director of nursing (CNS/DON)-C stated they observed ULPs perform medication administration to residents then sign documentation as evidence ULPs are competent to administer medications independently. CNS/DON-C stated they were unsure why the documentation could not be located. The licensee's 5.01 Orientation of Staff and Supervisors & Content policy dated May 31, 2024, indicated evidence of required orientation topics must be kept in the employee's record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380		
01470 SS=E	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff	01470		

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01470	Continued From page 38 person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated	01470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32258	A. BUILDING: _____ B. WING _____	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GENEVA SUITES	9145 MEADOWVIEW ROAD BLOOMINGTON, MN 55425

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01470	Continued From page 39 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 staff providing services completed an orientation to assisted living facility licensing requirements and regulations before providing services for two of three employees (unlicensed personnel (ULP)-F, ULP-G) 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: ULP-F ULP-F's employee file included [licensee] Offer of Employment signed by ULP-F June 16, 2019, to provide direct care services. ULP-F's employee record lacked evidence of orientation to assisted living regulations (Minnesota Statutes, chapter 144G.63,	01470		

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01470	Continued From page 40 subdivision 2) effective August 1, 2021, for the following: -Handling emergencies and using emergency services; -Assisted Living Bill of Rights; -Handing of resident complaints, reporting of complaints, where to report and; -Principles of person-centered planning/service delivery. ULP-G The licensee's Employee List indicated ULP-G was hired August 28, 2023, to provide direct care services. ULP-G's employee record lacked evidence of orientation to assisted living regulations (Minnesota Statutes, chapter 144G.63, subdivision 2) effective August 1, 2021, for the following: -Overview of Assisted Living statutes; -Review of provider's policies and procedures; -Handling emergencies and using emergency services; -Reporting maltreatment of vulnerable adults or minors; -Assisted Living Bill of Rights; -Handing of resident complaints, reporting of complaints, where to report; -Consumer advocacy services; -Review of types of Assisted Living services the employee will provide and provider's scope of license; and -Principles of person-centered planning/service delivery. On July 17, 2024, at 1:28 p.m., operations director (OD)-A stated there were no other documents for employee files and was unsure why there was missing documentation.	01470		

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01470	Continued From page 41 On July 18, 2024, at 9:22 a.m., licensed assisted living direct (LALD)-D stated they believed the training completed by staff members met the 144G statute requirements. LALD-D stated it was an oversight for staff not completing the required training. The licensee's 5.01 Orientation of Staff and Supervisors and Content policy dated May 31, 2024, indicated staff much complete an orientation to Assisted Living Facility licensing requirements and regulations before providing assisted living services to residents. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
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 store prescription medication securely to permit only authorized personnel to have access. 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	01880		

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01880	Continued From page 42 cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 was admitted to the facility on January 15, 2020, under the licensee's former comprehensive license and began receiving assisted living services on August 1, 2021. R2's diagnoses included diffuse traumatic brain injury, morbid obesity, major depressive disorder, chronic pain, hypertension, neuromuscular dysfunction of the bladder (problems urinating), symptoms and signs involving cognitive functions and awareness (problems with remembering, difficulty speaking and understanding), muscle weakness, peripheral vascular disease (lack of blood flow to limbs), and person injury in collision between other specified motor vehicles. R2's Care Plan (service plan) dated July 15, 2024, indicated R2 received assistance with medication management. R2 medication administration record (MAR) indicated R2 received the following medications: atorvastatin calcium 20 milligram (mg), Cerovite Senior 1 tablet by mouth once daily, lactase 3000 units (u) 3 tablets by mouth three times daily, melatonin 3 mg 3 tablets by mouth at bedtime, metoprolol succinate extended release (ER) 25 mg 1 tablet by mouth once daily, omeprazole 20 mg 1 capsule by mouth once daily, ramelteon 8 mg 1 tablet by mouth once daily, sertraline 25 mg 1 table by mouth once daily, trazadone 100 mg 2 tablets by mouth at bedtime, Vitamin D3 25	01880		

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01880	Continued From page 43 microgram (mcg) 1 table by mouth once daily, acetaminophen 500 mg 2 tablets by mouth as needed for pain, and loperamide 2 mg capsule 1 capsule by mouth as needed. On July 16, 2024, at 7:38 a.m., during a facility tour of the split-level home, in R2's bedroom on the upper level of the split-level home, the surveyor observed the following two medications in a gray bucket: Nystatin powder 100,000 units (u) and diclofenac sodium gel one percent (%). The Nystatin Powder 100,000 u bottle contained a pharmacy label identifying the medication was for R2. The diclofenan sodium gel one % contained a pharmacy label identifying the medication was for R2. R2's MAR lacked the medications Nystatin powder 100,000 u, and diclofenac sodium gel one %. R2's resident record lacked a prescription order from a medical provider for the medications Nystatin powder 100,000 u, and diclofenac sodium gel one %. R2's Individualized Medication Management Assessment dated March 5, 2024, indicated [licensee] would store and administer medications for the resident. On July 16, 2024, at 11:19 a.m., clinical nurse supervisor/director of nursing (CNS/DON)-C stated a signed order from a medical provider was required for a resident to keep medications in their bedrooms and it should be assessed by the registered nurse (RN) if a resident can safely store and self-administer medications. CNS/DON-C stated ULPs were trained to remove medications if they were found in resident's	01880		

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01880	Continued From page 44 rooms, and ULP's would leave medications in resident's rooms for "convenience." On July 16, 2024, at 11:25 a.m., unlicensed personnel (ULP)-F stated no medications should be stored in resident's rooms and they were trained to remove any medications found in resident's rooms and to inform a supervisor. ULP-F stated they were not aware of medications in R2's bedroom. The licensee's 7.20 Medication and Treatment order policy dated June 6, 2024, indicated any medications for residents requires a written prescriber's order. No other information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
02310 SS=E	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care, medical or nursing standards for two of six residents (R2, R3). This practice resulted in a level two violation (a	02310		

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02310	Continued From page 45 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 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: BEDRAILS R2 R2 was admitted to the facility on January 15, 2020, under the licensee's former comprehensive license and began receiving assisted living services on August 1, 2021. R2's Care Plan (service plan) dated July 15, 2024, indicated R2 received assistance with monitoring breathing patterns, assist with bathing, orienting to time and day, room cleaning, laundry, medication management, transfers, toileting, and ordering of supplies. R2's diagnoses included diffuse traumatic brain injury, morbid obesity, major depressive disorder, chronic pain, hypertension, neuromuscular dysfunction of the bladder (problems urinating), symptoms and signs involving cognitive functions and awareness (problems with remembering, difficulty speaking and understanding), muscle weakness, peripheral vascular disease (lack of blood flow to limbs), and person injury in collision between other specified motor vehicles. R2's Side Rail Use Assessment dated June 6, 2024, lacked the following required content: -zone measurements hospital bilateral bedrail.	02310		

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02310	Continued From page 46 R3 R3 was admitted to the facility on April 24, 2024, and began received assisted living services. R3's Care Plan dated July 15, 2024, indicated R3 received assisted with bathing, dressing, grooming, nail care, vital sign monitoring, housekeeping, laundry, safety check and toileting. R3's diagnoses included left side hemiplegia (paralysis of the left side), major depressive disorder, chronic pain syndrome, hypertension, dysphagia (difficultly speaking), heart failure, chronic obstructive pulmonary disease (lung disease), sleep disorder, mild cognitive impairment, and chronic kidney disease (kidney failure). R3's Side Rail Use Assessment dated May 5, 2024, lacked the following required content: -zone measurements of single hospital bedrail. On July 15, 2024, at 10:32 a.m., during a facility tour, the surveyor observed hospital bedrails installed on R2 and R3's beds. The bedrails for each resident were firmly attached and appeared to be in good repair. On July 16, 2024, at 10:39 a.m., clinical nurse supervisor/director of nursing (CNS/DON)-C stated the registered nurse (RN) was responsible for the bedrail assessments and was aware bedrail measurements should be included in the assessment, and it was "human error" for not including the measurements. On July 16, 2024, at 10:48 a.m., the surveyor observed CNS/DON-C measuring R2 and R3's bedrails. Each bedrail met the FDA side rail entrapment zone and dimensional	02310		

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02310	Continued From page 47 recommendations. The March 10, 2006, FDA Side Rail Entrapment Zones and Dimensional Recommendations indicated to reduce the risk of entrapment, zone 1 (within the rail) should not exceed 4 and 3/4 inches, zone 2 (under the rail, between rail supports or next to a single rail support) should not exceed 4 and 3/4 inches, zone 3 (between the rail and the mattress), should not exceed 4 and 3/4 inches, and zone 4 (under the rail, at the ends of the rail) should not exceed 2 and 3/8 inches or be greater than a 60 degree angle. The licensee 6.28 Side Rails policy dated June 17, 2024, indicated [licensee] would ensure bedrails follow the Food, and Drug Administration 2006 recommendations for dimensional measurements. SKIN CARE R2 On July 16, 2024, at 7:10 a.m., the surveyor observed unlicensed personnel (ULP)-F perform morning cares on R2. ULP-F entered R2's room, performed hand hygiene and donned gloves. R2 was sitting upright at the edge of their bed. ULP-F moved R2's walker in front of the resident and instructed them to stand. ULP-F stated they were going to change their adult brief. ULP-F unfastened the adult brief and placed it on the floor. The brief had discoloration to the front which indicated it had been soiled. ULP-F then applied a new clean adult brief onto R2. ULP-F did not clean the skin area including the buttocks, thighs, and genitals. On July 16, 2024, at 7:40 a.m., ULP-F stated they were trained to perform skin cares if a resident's skin was visibly soiled or wet, and R2's skin was	02310		

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02310	Continued From page 48 not soiled or wet when the adult brief was removed. On July 16, 2024, at 10:25 a.m., CNS/DON-D stated staff were trained to clean the skin area regardless of whether there was soiling or not. CNS/DON-D stated they were unsure why ULP-F did not perform the required skin care. The National Association for Continence Caring For Your Skin When You Have Incontinence recommends changing your product as often as possible to prevent any urine or stool from being trapped close to the skin for too long of a period. Clean and dry the area immediately after urinating or having a bowel movement. Use a mild soap that won't irritate your skin. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	02310		

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

Type: Full
Date: *07/16/24*
Time: 11:29:15
Report: 1018241111

Food and Beverage Establishment Inspection Report

Location:
The Geneva Suites
9145 Meadowview Road
Bloomington, MN55425
Hennepin County, 27

Establishment Info:
ID #: 0037626
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6122088888
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.

No NEW orders were issued during this inspection.

Food and Equipment Temperatures

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

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

ESTABLISHMENT IS A RESIDENTIAL HOME WITH RESIDENTIAL EQUIPMENT.

FLOORS, WALLS AND CEILINGS WERE OBSERVED TO BE IN GOOD CONDITION DURING THIS INSPECTION AND WILL BE MONITORED THROUGH THE YEARS.

ESTABLISHMENT DOES ALL SAME DAY SERVICE OF FOOD.

KITCHEN HAS A TWO BASIN SINK AND A DEDICATED HAND WASHING SINK.

DISHWASHER HAS SANITIZE FUNCTION AVAILABLE.

FOOD COMES IN THROUGH THEIR OWN PRIVATE SUPPLIER AND IS SOMETIMES HOT HELD FOR RESIDENTS.

VIEWED HOT AND COLD HOLDING LOGS.

DISCUSSED EMPLOYEE ILLNESS AND ILLNESS REPORTING.

Type: Full
Date: *07/16/24*
Time: 11:29:15
Report: 1018241111
The Geneva Suites

Food and Beverage Establishment Inspection Report

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

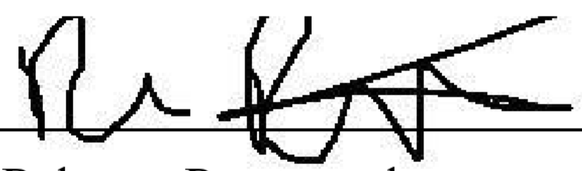
I acknowledge receipt of the Minnesota Department of Health inspection report number 1018241111 of 07/16/24.

Certified Food Protection Manager: LESLIE KEMP

Certification Number: FM112097 Expires: 07/20/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
LESLIE KEMP

Signed: 
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