Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF REMOVAL OF CONDITIONAL LICENSE

Electronic Delivery

December 17, 2024

Licensee
Bright Living LLC
7309 Zane Avenue North
Brooklyn Park, MN 55443

RE: License Number 417226
Health Facility Identification Number (HFID) 34608
Project Number(s) SL34608015

Dear Licensee:

On December 3, 2024, The Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed August 19, 2024. The follow-up survey found the facility to be in substantial compliance. **Based on these findings, the condition(s) on the license were removed effective December 17, 2024.**

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

Furthermore, the follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the August 19, 2024, initial survey.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a), state correction orders issued pursuant to the last survey completed on August 19, 2024, found not corrected at the time of the follow-up survey follow-up survey and/or subject to a penalty assessment are as follows:

1290-Background Studies Required-144g.60 Subdivision 1 - $500.00

The details of the violations noted at the time of this follow-up survey completed on December 3, 2024 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Also, at the time of this follow-up survey completed on December 3, 2024, we identified the following violation(s):

0830-Local Laws Apply-144g.45 Subd. 3

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

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

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

The correction order documentation should include the following:

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

IMPOSITION OF FINES:

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

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

To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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

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

To submit a hearing request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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

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

Sincerely,

Rick Michals, J.D.
Executive Regional Operations Manager

Minnesota Department of Health
Health Regulation Division

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34608	A. BUILDING: _____ B. WING _____	R 12/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHT LIVING LLC	7309 ZANE AVENUE NORTH BROOKLYN PARK, MN 55443

(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: SL34608015-1 On December 2, 2024, through December 3, 2024, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on August 19, 2024. At the time of the survey, there were two (2) residents receiving services under the Assisted Living license. As a result of the follow-up survey, the following orders were issued or 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.	
{0 100} SS=F	144G.10 Subdivision 1 License required (a)(1)Beginning August 1, 2021, no assisted living	{0 100}		

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{0 100}	Continued From page 1	{0 100}		

facility may operate in Minnesota unless it is licensed under this chapter.

(2) No facility or building on a campus may provide assisted living services until obtaining the required license under paragraphs (c) to (e).

(b)The licensee is legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. Nothing in this chapter shall in any way affect the rights and remedies available under other law.

(c) Upon approving an application for an assisted living facility license, the commissioner shall issue a single license for each building that is operated by the licensee as an assisted living facility and is located at a separate address, except as provided under paragraph (d) or (e).

(d) Upon approving an application for an assisted living facility license, the commissioner may issue a single license for two or more buildings on a campus that are operated by the same licensee as an assisted living facility. An assisted living facility license for a campus must identify the address and licensed resident capacity of each building located on the campus in which assisted living services are provided.

(e) Upon approving an application for an assisted living facility license, the commissioner may:

(1) issue a single license for two or more buildings on a campus that are operated by the same licensee as an assisted living facility with dementia care, provided the assisted living facility for dementia care license for a campus identifies the buildings operating as assisted living facilities with dementia care; or

(2) issue a separate assisted living facility with dementia care license for a building that is on a campus and that is operating as an assisted living facility with dementia care.

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{0 100}	Continued From page 2 This MN Requirement is not met as evidenced by:	{0 100}	This correction order was not reviewed during this survey.	
{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:	{0 480}	Not reviewed during this survey.	
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 and interview, the licensee failed to comply with all state and local governing laws, and codes, building permit, and Minnesota Department of Health (MDH) construction approvals. 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	0 830		

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0 830	Continued From page 3 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 a facility tour on December 2, 2024, from 11:15 a.m. to 11:45 a.m., with licensed assisted living director (LALD)-A, the surveyor made the following observations of facility non-compliance with all state and local governing laws and rules: There was construction work in progress including the attached bathroom in resident sleeping room 4. The construction work included removal of plumbing fixtures, removal and replacement of drywall wall cover behind the bathroom sink and toilet, wall finish updating, ceiling finish updates, and floor covering removal. During the tour the surveyor asked if there was a building permit from the local building code authority and approval for construction from MDH. During a facility tour and interview on December 2, 2024, at 11:30 a.m., LALD-A, verified the above listed observations while accompanying on the tour and stated they were not aware of the property owner applying for a building permit or submitting a construction application to MDH. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 830		

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{01290}	Continued From page 4	{01290}		
{01290} SS=F	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure background studies (BGS) were associated with the licensee's current assisted living facility's health facility identification (HFID) number for two of two unlicensed personnel ((ULP)-F and ULP-H). 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:	{01290}		

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{01290}	Continued From page 5 The licensee's current assisted living HFID issued on August 1, 2021, was 34608. The licensee's previous comprehensive home care license HFID was 34319. ULP-G ULP-G was hired on November 6, 2024. ULP-G's BGS Notice dated October 21, 2024, indicated ULP-G was associated with HFID 34319. ULP-H ULP-H was hired September 26, 2024. ULP-H's BGS Notice dated September 26, 2024, indicated ULP-H was associated with HFID 34319. ULP-G and ULP-H's record lacked a BGS Notice associated with licensee's current assisted living HFID. On December 2, 2024, at 11:40 a.m., licensed assisted living director (LALD)-A stated they had associated licensee's employees with licensee's previously held comprehensive license HFID instead of the current assisted living license HFID. LALD-A stated licensee would need to associate all employees with the current HFID as only one active employee had been associated with the current assisted living license HFID. The licensee's Personnel Records policy dated February 15, 2022, indicated the licensee would maintain current results of employee's BGS, however the policy lacked indication the licensee would associate each employee with the current	{01290}		

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{01290}	Continued From page 6 HFID. No further information provided.	{01290}		

Protecting, Maintaining and Improving the Health of All Minnesotans

AMENDED

NOTICE OF CONDITIONAL LICENSE

Electronically Delivered

December 4, 2024

Licensee
Bright Living LLC
7309 Zane Avenue North
Brooklyn Park, MN 55443

RE: Conditional License Number 417226
Health Facility Identification Number (HFID) 34608
Project Number(s) SL34608015

Dear Licensee:

Please Note: This notice amends the Notice of Conditional License dated September 20, 2024. Specifically, correction order 0100 was amended to reflect accurate description of dwelling. Also, please note that an additional request for an informal conference has been included in this amended letter. Refer to this notice and revised state form for additional details.

The Minnesota Department of Health (MDH) completed a survey on August 19, 2024, for the purpose of assessing compliance with state licensing statutes. Based on the survey results you were found not to be in substantial compliance with the laws pursuant to Minnesota Statutes, Chapter 144G.

As a result, pursuant to Minn. Stat. § 144G.20, MDH is issuing a 90-day conditional license due to expire on **December 19, 2024**.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

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

MDH may assess fines based on the level and scope of the orders outlined below. The total amount of **potential** fines that may be assessed related to these correction orders is $6,500.00. **MDH is not imposing these fines against your license at this time.**

0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00
1290 - 144g.60 Subdivision 1 - Background Studies Required - $3,000.00
1750 - 144g.71 Subd. 7 - Delegation Of Medication Administration - $3,000.00

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 and immediately correct any reissued orders outlined on the state form; however, plans of correction are not required to be submitted for approval. **If corrections are not made, MDH may impose fines as described above and in accordance with Minnesota Statutes 144G.**

The correction order documentation should include the following:

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

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

A state correction order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is

substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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.

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

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

a. **No new substantiated maltreatment allegations:** If any new investigations begin in the conditional license period, and the allegations are substantiated, MDH may pursue additional enforcement actions up to and including immediate temporary suspension and revocation of the license.

b. **No new admissions:** Bright Living LLC will not admit any new residents under its conditional assisted living facility license until MDH removes the “no new admissions” condition. Bright Living LLC must provide the Department:

   i. A list of the names and birthdates of any individuals Bright Living LLC is currently in the process of admitting. These individuals will be able to continue the admittance process.

   ii. A list of all current residents by location including:
      1. Name and birthdate of each resident

2. Physical location of each resident
3. Current payment source for services
4. If Elderly Waiver, the name and contact information of the care coordinator/case manager
5. If the resident is not able to make informed decisions, the name of their representative and how to contact the representative

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

d. **Reports:** The RN consultant will provide MDH with regular reports at intervals specified by MDH. Reports will begin on a weekly basis until MDH notifies Bright Living LLC and the RN consultant about a change. Each report will be electronically submitted to Jessie Chenze, Surveyor Supervisor, State Evaluation Team, Health Regulation Division, at jessie.chenze@state.mn.us. Jessie Chenze can be reached at 218-332-5175 (office) with questions about reports. The content of the reports will include information such as:

i. Progress towards correction of orders;
ii. Observations of staff delivering assisted living services and the level of competency observed;
iii. Conversations with residents and family members about satisfaction with assisted living services;
iv. Conversations with staff about their level of knowledge about the tasks they perform, the people they serve and the health professionals who delegate to them;
v. Overall impressions about the quality of the assisted living services delivered;
vi. Overall impressions about the dignity with which the residents and their family members are treated;

vii. Concerns; and
viii. Any other information requested by the Department or considered important by the RN consultant(s).

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

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

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

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

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

REQUESTING A HEARING:

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

INFORMAL CONFERENCE
In accordance with Minn. Stat. § 144A.475, Subd. 8 OR Minn. Stat. § 144G.20, Subd. 20, the Commissioner of Health is authorized to hold a conference to exchange information, clarify issues, or resolve issues. The Department of Health staff would like to schedule a conference call with Bright Living LLC. **Please contact Jessie Chenze at 218-332-5175, on or before Monday, December 9, 2024.**

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 Jessie Chenze directly at: 218-332-5175.

Sincerely,

Rick Michals

Rick Michals, J.D.
Executive Regional Operations Manager

Minnesota Department of Health
Health Regulation Division

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34608	A. BUILDING: _____ B. WING _____	08/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHT LIVING LLC	7309 ZANE AVENUE NORTH BROOKLYN PARK, MN 55443

(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: SL34608015-0 On August 13, 2024, through August 19, 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 two residents receiving services under the provider's Assisted Living Facility license. Immediate correction orders were identified on August 14 and August 15, 2024, for project SL34608015, tag identification 1290 and 1750 respectively, both issued at scopes and levels of widespread, level three (l). On November 26, 2024, correction order 0100 was amended to reflect accurate description of dwelling.	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.	

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0 100	Continued From page 1	0 100		
0 100 SS=F	144G.10 Subdivision 1 License required (a)(1)Beginning August 1, 2021, no assisted living facility may operate in Minnesota unless it is licensed under this chapter. (2) No facility or building on a campus may provide assisted living services until obtaining the required license under paragraphs (c) to (e). (b)The licensee is legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. Nothing in this chapter shall in any way affect the rights and remedies available under other law. (c) Upon approving an application for an assisted living facility license, the commissioner shall issue a single license for each building that is operated by the licensee as an assisted living facility and is located at a separate address, except as provided under paragraph (d) or (e). (d) Upon approving an application for an assisted living facility license, the commissioner may issue a single license for two or more buildings on a campus that are operated by the same licensee as an assisted living facility. An assisted living facility license for a campus must identify the address and licensed resident capacity of each building located on the campus in which assisted living services are provided. (e) Upon approving an application for an assisted living facility license, the commissioner may: (1) issue a single license for two or more buildings on a campus that are operated by the same licensee as an assisted living facility with dementia care, provided the assisted living facility for dementia care license for a campus identifies the buildings operating as assisted living facilities with dementia care; or (2) issue a separate assisted living facility with	0 100		

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0 100	Continued From page 2 dementia care license for a building that is on a campus and that is operating as an assisted living facility with dementia care. This MN Requirement is not met as evidenced by: **Correction order amended on November 26, 2024.** Based on observation, interview, and record review, the licensee failed to manage, control, and/or operate the entire building as an assisted living facility. Non-assisted living occupants reside on one side of the duplex/townhome, and the licensee does not have access to all areas of the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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 health facility identification (HFID 34608), a building, was located at 7309 Zane Avenue North, Brooklyn Park, MN, 55443, and shared two walls adjoining occupied residential townhomes under the same roof. During entrance conference on August 13, 2024, at 11:41 a.m., licensed assisted living director (LALD)-A stated the licensee was familiar with current minimum assisted living requirements.	0 100		

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0 100	Continued From page 3 On August 13, 2024, at 1:19 p.m., the surveyor toured the facility with LALD-A and the engineer surveyor from the Minnesota Department of Health (MDH). During the tour, the surveyor observed the facility as part of multi-unit town homes. Each unit of the town homes had a private entrance; however, all units shared an adjoining wall with another unit, under one roof. LALD-A stated the other town homes which the licensee shared a common wall were occupied by a private party. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 100		
0 250 SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in	0 250		

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0 250	Continued From page 4 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. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the	0 250		

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0 250	Continued From page 5 management officials who were in charge of the day-to-day operations; and responsible for the resident's assisted living services, understood all of the assisted living facility regulations. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During entrance conference on August 13, 2024, at 11:41 a.m., licensed assisted living director (LALD)-A stated the licensee was familiar with the assisted living regulations. 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]: - I have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section] 144G.45 (opens in a new window), 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 (opens in a new window). - I have read and fully understand Minn. Stat. sect. 144G.80 (opens in a new window), 144G.81 (opens in a new window). and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22 (opens in a new window), my building(s) must comply with	0 250		

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0 250	Continued From page 6 these sections if applicable. - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G (opens in a new window). - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659 (proposed and not final) (opens in a new window). - Reporting of Maltreatment of Vulnerable Adults (opens in a new window). - Electronic Monitoring in Certain Facilities (opens in a new window)." - "I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G (opens in a new window), and Minnesota Rules, chapter 4659 (proposed and not final) (opens in a new window), 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 f 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 (opens in new window). and Minn. Rules chapter 4659 (proposed and not final) (opens in new window), in place upon licensure and to keep them current as applicable." Page six was electronically signed by LALD-A on May 7, 2024. The licensee had an assisted living license,	0 250		

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0 250	Continued From page 7 effective July 1, 2024. The licensee failed to ensure the following policies and procedures were developed and/or implemented: - infection control practices; - orientation and training of staff; - handling complaints regarding staff or services provided by staff; - conducting initial and ongoing resident evaluations and assessments of resident needs: - conducting and handling background studies on employees; - medication and treatment management; and - delegation of tasks by registered nurses or licensed health professionals. As a result of the survey, the following correction orders were issued, 0100, 0250, 0460, 0470, 0480, 0510, 0650, 0660, 0680, 0690, 0720, 0780, 0800, 0810, 0970, 1290, 1370, 1380, 1460, 1470, 1490, 1530, 1640, 1710, 1750, 1760, 1790, 1820, 1830, 1880, 1890, 1910, 1950, 1970 which indicated the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.01 to 144G.95. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21)	0 250		
0 460 SS=F	144G.41 Subdivision 1 Minimum requirements (5) provide a means for residents to request assistance for health and safety needs 24 hours per day, seven days per week; (6) allow residents the ability to furnish and	0 460		

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0 460	Continued From page 8 decorate the resident's unit within the terms of the assisted living contract; (7) permit residents access to food at any time; (8) allow residents to choose the resident's visitors and times of visits; (9) allow the resident the right to choose a roommate if sharing a unit; (10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living facility must not lock a resident in the resident's unit; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide a means for residents to request assistance for health and safety needs 24 hours a day, seven days a week. This had the potential to affect all residents residing at the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee held an assisted living facility license and was licensed for a capacity of four residents, with a census of two residents residing	0 460		

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0 460	Continued From page 9 in the facility. During entrance conference on August 13, 2024, at 11:41 a.m., licensed assisted living director (LALD)-A stated the license did not have a system in place for residents to summons staff for assistance. During the facility tour on August 13, 2024, at 1:43 p.m., with LALD-A, no call system was observed in resident rooms to summons staff. The licensee's Uniform Disclosure of Assisted Living Service and Amenities (UDALSA) dated May 13, 2022, indicated the licensee did not provide an emergency call system. No other information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 460		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans 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	0 470		

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0 470	Continued From page 10 available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the clinical nurse supervisor (CNS) reviewed the licensee's staffing plan to determine staffing levels to meet the needs of all residents at a minimum twice a year as required. In addition, the licensee failed to ensure the daily staffing schedule was posted in a central location. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The finding include: The licensee held an assisted living facility license and was licensed for a census of four residents.	0 470		

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0 470	Continued From page 11 During the facility tour on August 13, 2024, at 1:43 p.m., with licensed assisted living director (LALD)-A, the daily staffing schedule was not observed posted in the facility. LALD-A stated the staff schedule was usually posted on the bulletin board and did not know why the schedule was not posted. On August 14, 2024, at 12:00 p.m., clinical nurse supervisor (CNS)-B provided the licensee's staffing plan and policy. The licensee's Staffing Plan had an effective date of June 1, 2023, and listed the next evaluation date for January 8, 2024. CNS-B was unable to provide documentation the staffing plan was reviewed prior to after June 1, 2023. The licensee's Staffing policy dated February 25, 2022, indicated the staffing plan shall be evaluated as part of Quality Management program at least twice a year. The results of the evaluation are documented in the meeting minutes. The schedule would be posted at the beginning of the shift in a central location in each building, if applicable, accessible to staff, residents, volunteers and the public. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 470		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according	0 480		

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0 480	Continued From page 12 to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated August 13, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the	0 510		

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0 510	Continued From page 13 national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to establish and maintain an infection control program to comply with acceptable health care, medical nursing standards for infection control after medication administration for one of one (unlicensed personnel (ULP)-C and ensuring the licensee provided adequate supplies to perform proper hand hygiene. 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 August 13, 2024, at 1:31 p.m., during the facility tour with licensed assisted living director (LALD)-A, the surveyor did not observe hand soap, hand sanitizer, hand towels or paper towels in the shared bathroom on the second floor, in the bathroom located on the first floor or by the kitchen sink.	0 510		

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0 510	Continued From page 14 The licensee's Minnesota Department of Health Food and Beverage Establishment Inspection Report dated August 13, 2024, indicated the licensee did not have soap available for hand washing at either kitchen sink or bathroom sinks. On August 14, 2024, at 2:25 p.m., LALD-A instructed ULP-C to go to the store and buy a box of gloves before ULP-C assisted R2 with insulin administration. LALD-A stated the licensee must have just ran out of gloves and sent ULP-C to the store to purchase more. At 2:38 p.m., ULP-C returned with one box of stretch vinyl exam gloves and stated he only purchased one box of gloves and was unsure how long the licensee was without gloves. At 2:39 p.m., the surveyor observed ULP-C gather R2's Novolog (rapid-acting) prefilled insulin pen insulin, dial 12 units of insulin, and inject into R2's left upper arm. ULP-C disposed of needle cap into the sharps container, removed gloves, put R2's Novolog insulin into the medication cabinet and documented the administration of R2's insulin in R2's electronic medical administration record. ULP-C did not perform hand hygiene after the removal of gloves. Immediately following R2's insulin administration, ULP-C stated he did not realize he did not perform hand hygiene after the removal of gloves and should have. On August 14, 2024, at 3:30 p.m., licensed assisted living director (LALD)-A stated hand washing should be performed before and after administering resident medications and treatments. LALD-A stated the licensee replenished hand soap for staff and residents to wash their hands. The licensee's Infection Control policy dated February 15, 2022, indicated hands are washed if	0 510		

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0 510	Continued From page 15 contaminated with blood or bodily fluid, immediately after gloves are removed, between resident contacts, and when indicted to prevent the transfer of microorganisms between resident or the environment. Gloves were work when touching blood, body fluids, secretions, excretions, non-intact skin, mucus membranes, or contaminated items. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 650 SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as	0 650		

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0 650	Continued From page 16 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 two employees (unlicensed personnel (ULP)-E). 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-E was hired June 16, 2023, to provide direct care services to residents of the assisted living facility. On August 15, 2024, at 8:06 a.m., the surveyor observed ULP-E administering R3's scheduled morning medications. On August 15, 2024, at 8:13 a.m., the surveyor observed ULP-E gather R2's Novolog prefilled insulin pen, dial 12 units of insulin, and inject into R2's right upper arm. ULP-E did not prime the Novolog insulin pen two units before dialing the prescribed dose and administering R2's insulin. ULP-E's employee record lacked evidence ULP-E received the following training and demonstrated competencies as required: -documentation of requirements for all services;	0 650		

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0 650	Continued From page 17 -reports of changes in the client's condition to the supervisor designated by the facility; -maintenance of a clean and safe environment -appropriate and safe techniques in personal hygiene and grooming, including: -hair care and bathing; -care of teeth and gums, and oral prosthetic devices; -care and use of hearing aids; and -dressing and assisting with toileting; -training on the prevention of falls for providers working with the elderly or individuals at risk of falls; -standby assistance techniques and how to perform them; -medication, exercise, and treatment reminders; -basic nutrition, meal preparation, food safety, and assistance with eating; -preparation of modified diets as ordered by a licensed health professional; -communication skills that include preserving the dignity of the client and showing respect for the client and the client's preferences, cultural background, and family; -awareness of confidentiality and privacy; -understanding appropriate boundaries between staff and clients and the client's family; -procedures to utilize in handling various emergency situations; -awareness of commonly used health technology equipment and assistive device; -observing, reporting, and documenting resident status; -basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; -reading and recording temperature, pulse, and respirations of the resident; -recognizing physical, emotional, cognitive, and	0 650		

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0 650	Continued From page 18 developmental needs of the client; -safe transfer techniques and ambulation; -range of motioning and positioning; -administering medications or treatments as required; and -other RN/professionally delegated tasks (i.e., monitor vital signs, catheter or stoma care, Broda chair, mechanical lifts). On August 15, 2024, at 12:40 p.m., licensed assisted living director (LALD)-A stated she was unable to find documentation in ULP-E employee record required training and competency evaluations noted above. LALD-A stated in the past, staff training was completed on Educare (electronic training program) but the licensee reverted back to paper. On August 15, 2024, at 10:57 a.m., ULP-E stated she was trained by the previous nurse upon hire on medication administration and her training was all recorded on paper, including the topics listed above. The licensee's Personnel Records policy dated February 15, 2022, indicted a record of each paid employee, regularly scheduled volunteer providing assisted living services, and each individual contractor providing assisted living services for the licenses would be maintained and include a minimum documentation of orientation and competency evaluations. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		

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0 660	Continued From page 19	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 an up-to-date completion of a facility risk assessment. 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:	0 660		

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0 660	Continued From page 20 On August 14, 2024, at 11:18 a.m., the surveyor reviewed the licensee's Facility TB Risk Assessment Worksheet for Health Care Settings Licensed by Minnesota Department of Health (MDH) dated February 24, 2020. Clinical nurse supervisor (CNS)-B provided an additional Facility TB Risk Assessment; however, lacked the date the TB facility risk assessment was completed and lacked a signature of the person who completed the form. CNS-B stated she was unable to find a more current facility TB risk assessment. The licensee's Tuberculosis Screening/Prevention policy dated August 1, 2021, indicated the director was responsible for conducting the formal TB Risk Assessment and updating annually. The Minnesota Department of Health (MDH) guidelines Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July 2013, and based on CDC guidelines, indicated a TB risk assessment should be completed initially and then for low-risk settings the risk assessment should be updated every other year. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that	0 680		

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0 680	Continued From page 21 contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and post a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all residents, staff, and visitors of the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	0 680		

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0 680	Continued From page 22 The findings include: During the entrance conference on August 13, 2024, at 11:41 a.m., licensed assisted living director (LALD)-A stated she was responsible for developing and maintaining the licensee's EPP. LALD-A stated the EPP was in a binder locked in the medication storage cabinet. LALD-A confirmed the licensee's EPP was not prominently posted in the facility and residents or visitors did not have access unless the staff unlocked the cabinet. The licensee's EPP dated February 15, 2022, provided to the surveyor included generic instructions for staff to follow in case of a fire, severe weather, and an evacuation. The licensee's EPP lacked the following: - documentation of annual review of EPP; - a quarterly review of missing resident policy; - a facility's Hazard Vulnerability Analysis (HVA) include man-made disasters, facility based (power, water etc.), infectious diseases and pandemics; - a description of the population served by the licensee; - development of policies/procedures to address: - procedure for tracking staff and residents; - subsistence needs for staff and residents during an emergency to include (food, water, medical supplies, pharmacy supplies, sewer and waste disposal, emergency lighting, fire detection, extinguishing and alarm systems; - evacuation plan which included staff responsibilities during an evacuation and transporting services for residents being evacuated; and - a communication plan that included: - arrangements with other facilities/providers to receive residents;	0 680		

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0 680	Continued From page 23 - names and contact information for staff, entities providing services under arrangement, resident physicians, other facilities, volunteers; - contact information for federal, state, tribal, local EP staff, ombudsman, state licensing and certification agencies; - primary and alternative means for communicating with facility staff, federal, state, regional and local emergency management agencies; - a means to provide information regarding the facility's needs, and its ability to provide assistance to include information about their occupancy; and - an EP training and testing program On August 13, 2024, at 2:36 p.m., the surveyor reviewed the licensee's EPP with LALD-A. LALD-A stated the licensee's EPP was locked in the medication storage cabinet and was not available to residents, visitors or staff who do not have a key. On August 15, at 4:25 p.m., the surveyor reviewed the licensee's EPP with LALD-A, and LALD-A stated she was not aware the missing resident policy was required to be reviewed quarterly and the licensee's EPP needed more work. The licensee's Emergency Preparedness policy dated August 1, 2021, indicated the licensee would have an identified plan in place to assure the safety and well-being of residents and staff during periods of an emergency disaster that disrupts services. The emergency preparedness plan/program would be reviewed/updated annually. No further information was provided.	0 680		

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0 680	Continued From page 24 TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 690 SS=D	144G.43 Subdivision 1 Resident record (a) Assisted living facilities must maintain records for each resident for whom it is providing services. Entries in the resident records must be current, legible, permanently recorded, dated, and authenticated with the name and title of the person making the entry. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain resident records with current, legible, permanently recorded, dated, and authenticated with the name and title of the person making the entry for one of one resident (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: R3's diagnoses included bipolar, anxiety, hallucinations, agitation, paranoia, aggressiveness, and post-traumatic stress disorder (PTSD).	0 690		

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0 690	Continued From page 25 R3's Service Plan dated March 24, 2024, indicated R3 received medication administration, behavioral management, laundry, and housekeeping; however, lacked authentication of the date and title of the person who completed R3's service plan. In addition, R3's Nursing Assessment lacked authentication of the date and title of the person who completed R3's assessment. On August 14, 2024, at 10:23 a.m., clinical nurse supervisor (CNS)-B reviewed R3's service plan and nursing assessment and stated she was unsure why either documents were not signed and confirmed R3's service plan and nursing assessment were not signed by the person who completed the documents. The licensee's Clinical Records dated February 15, 2022, indicated a current clinical record shall be maintained for all residents. All entries into the clinical record would be legible, permanently recorded in ink, dated and authenticated with the name and title of the person making the entry. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 690		
0 720 SS=D	144G.43 Subd. 2 Access to records The facility must ensure that the appropriate records are readily available to employees and contractors authorized to access the records. Resident records must be maintained in a manner that allows for timely access, printing, or transmission of the records. The records must be made readily available to the commissioner upon	0 720		

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0 720	Continued From page 26 request. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure that the appropriate records for two of two residents (R2, R3), were readily available for timely access to employees, vendors, and the commissioner authorized to access the records. 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: During entrance conference on August 13, 2024, at 11:41 a.m., licensed assisted living director (LALD)-A stated resident records were mostly in paper form and the medication administration records (MAR) were electronic. LALD-A stated employees records were paper form and both employee and resident records were stored onsite in a secured office. On August 13, 2024, at 3:05 p.m., the surveyor requested R2's medical records for review. At 3:09 p.m., LALD-A stated she had to leave for a family emergency and would return the next day. At 3:13 p.m., the surveyor requested R2's medical record from unlicensed personnel (ULP)-E. ULP-E stated LALD-A had left for the day and the residents records were locked in the office and she did not have key to the office. At	0 720		

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0 720	Continued From page 27 3:21 p.m., ULP-C stated resident charts were in the office and LALD-A had to leave for day and the office was locked and he did not have a key. ULP-C stated LALD-A must have taken the keys with her and the keys ULP-C had did not access the office. ULP-C stated residents medication administration records (MAR) were electronic but all other resident information was in paper form was in the office and did not have access to the records including the residents plan of care. On August 14, 2024, at 8:10 a.m., the surveyor informed LALD-A staff were unable to access resident records or provide resident records to the surveyor upon request on August 13, 2024, after LALD-A had left for the day. LALD-A stated she was unaware staff could not have keys to the office to access resident records and could have called her if needed and would make sure extra an key was available. The licensee's Clinical Records policy dated February 15, 2022, indicated clinical records would be maintained in such a manner that allowed for a timely access, printing, or transmission of the records. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 720		
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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	34608	A. BUILDING: _____ B. WING _____	08/19/2024

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0 780	Continued From page 28 (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 interconnected smoke alarms throughout the facility. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). Findings include:	0 780		

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0 780	Continued From page 29 On a facility tour on August 13, 2024, from 1:30 p.m. to 2:45 p.m., with licensed assisted living director (LALD)-A, it was observed that smoke alarms were not interconnected so activation of one alarm activates all alarms throughout the facility. During the tour LALD-A, tested the alarms and none of the alarms were interconnected so activation of one alarm activates all alarms throughout the facility. All dwelling units required to have multiple smoke alarms are required to have interconnected alarms so activation of one alarm activates all alarms within the dwelling unit. During the tour the smoke alarms were tested and LALD-A, verified the smoke alarms were not interconnected so activation of one alarm activates all alarms throughout the facility. TIME PERIOD FOR CORRECTION: Two (2) day.	0 780		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the facility's physical environment in a continuous state of good repair	0 800		

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0 800	Continued From page 30 and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a 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 a facility tour on August 13, 2024, from 1:30 p.m. to 2:45 p.m., with licensed assisted living director (LALD)-A, the surveyor made the following observations of facility hazard or disrepair: There were cigarette butts on the floor in the garage. An appropriate cigarette butt dispenser was provided outside the garage door in the designated smoking area. There was an exit sign on the door of the garage leading occupants from the assisted living through the garage as an exit route. Occupants shall not be directed through the garage as an exit as it is a higher hazard area then the assisted living in accordance with current Minnesota Fire Code. There was a blanket screwed and nailed to the trim around the emergency escape and rescue window preventing access to the window. Emergency escape and rescue openings are required to be readily openable without the use of	0 800		

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0 800	Continued From page 31 tools or special knowledge in accordance with current Minnesota Fire Code. The light switch was broken at the top of the second-floor stairway controlling the upstairs hallway light. The vinyl sheet flooring was loose laid over the top of the carpet floor covering below creating a trip hazard in resident sleeping room 1 upstairs and 4 in the lower level. The vinyl sheet floor is required to be installed according to manufactures installation instructions directly to the solid surface of the floor. There were no room numbers matching the evacuation plan provided on or adjacent to the resident room doors in order to identify the room for direction to an exit in the event of a fire or similar emergency. The electrical light fixture cover was missing on the ceiling in resident sleeping room 2, and above the clothes washer and dryer in the lower level. Electrical light fixture covers are required to be maintained installed according to manufactures installation instructions and current Minnesota Fire Code. The ceiling finish material was coming off the ceiling from moisture in the bathroom of resident sleeping room 4. During a facility tour on August 13, 2024, at 2:45 p.m., LALD-A, verified the above listed observations while accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 800		

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0 810	Continued From page 32	0 810		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by:	0 810		

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0 810	Continued From page 33 Based on observation, interview and record review, the licensee failed to develop the fire safety and evacuation plan with required content, make the plan readily available, provide required training and drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During observation on August 13, 2024, at 2:45 p.m., the surveyor observed the fire safety and evacuation plan was not located in a central location for all staff and occupants accessibility. The plan was located in a locked file cabinet near the balcony door. The FSEP is required to be kept available for all building occupants. On August 13, 2024, at 2:45 p.m., licensed assisted living director (LALD)-A, provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The licensee provided FSEP dated February 15, 2022, failed to include the following: The location number of resident sleeping rooms were not provided on the evacuation floor plan and the plan was not posted in a conspicuous	0 810		

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0 810	Continued From page 34 location for use by occupants to navigate to an exit in the event of a fire or similar emergency. The available FSEP did not identify specific fire protection actions for residents as evident by not providing procedures for residents to take in the event of a fire or similar emergency in writing in the plan. The available 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 resident evacuation status and unique needs for each individual resident for evacuation in writing. During an interview on August 13, 2024, at 2:50 p.m., LALD-A, stated the above listed documentation was not available. TRAINING Record review of the available documentation indicated the licensee failed to provide training to employees on the FSEP upon hire and/or at least twice per year as evident by not providing documentation the required employee training was completed. Record review of the available documentation indicated the licensee failed to provide evacuation training to residents at least once per year as evident by not providing documentation training was provided based on the resident procedures required in the event of a fire or similar emergency. During an interview on August 13, 2024, at 3:00	0 810		

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0 810	Continued From page 35 p.m., LALD-A, stated documentation was not available for employee and resident training based on the FSEP. DRILLS Record review of the available documentation indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month as evident by providing documentation evacuation drills were completed January 6, 2024, and June 6, 2024, only. During an interview on August 13, 2024, at 3:10 p.m., LALD-A, stated the only evacuation drill documentation available was for January 6, 2024, and June 6, 2024. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
0 970 SS=C	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. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the assisted living contract did not include language waiving	0 970		

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0 970	Continued From page 36 the facility's liability for health, safety, or personal property of a resident for two of two residents (R2, 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 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's diagnoses included schizophrenia and diabetes. On August 14, 2024, at 2:39 p.m., the surveyor observed unlicensed personnel (ULP)-C monitor R2's blood sugar with the Libre monitor and administer R2 12 units of Novolog (rapid-acting) insulin. R2's Service Plan dated July 22, 2022, indicated R2 received medication administration, behavioral management, laundry, and housekeeping. R3 R3's diagnoses included bipolar, anxiety, hallucinations, agitation, paranoia, aggressiveness, and post traumatic stress disorder (PTSD). On August 15, 2024, at 8:06 a.m., the surveyor observed ULP-E administering R3's scheduled morning medications.	0 970		

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0 970	Continued From page 37 R3's Service Plan dated March 24, 2024, indicated R3 received medication administration, behavioral management, laundry, and housekeeping. R2 and R3's Assisted Living Contract signed July 22, 2022, included the following waiver of liability language: -under Insurance Liability and Release section- indicted the resident agrees the licensee would not be liable to the resident for any personal injury or property damage (including, without limitation, damage to, or loss or theft of, automobiles or personal property of resident, suffered by the resident or the resident's agents, guests or invitees, unless and to the extent that that the injury or damage is cause by the negligence of the licensee or its employees or agents. The resident releases the licensee from liability for any personal injury or property damage suffered the resident or the resident's agent, guest, or invitee, unless caused by the negligence of the licensee or its employees or agents; and -under Indemnification, indicated the licensee shall not be liable for any damage or injury to the resident, or any other person, or property, occurring on the premises, or any part thereof, or in common areas thereof, and the resident aggress to hold the licensee harmless from any claims or damages unless caused solely by negligence of the licensee. On August 13, 2024, at 2:20 p.m., licensed assisted living director (LALD)-A stated the licensee's assisted living contract was the same contract used for all residents. LALD-A confirmed the waiver of liability language in the assisted living contract and was unaware of the requirement.	0 970		

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0 970	Continued From page 38 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 970		
01290 SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure all employees with access to residents and resident records had a cleared background study completed via Minnesota Department of Human Services (DHS)NetStudy 2.0, for one of six employees (unlicensed personnel (ULP)-D). This had the potential to affect all residents, employees, and visitors. 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,	01290		

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01290	Continued From page 39 or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). This resulted in an immediate correction order on August 14, 2024. The findings include: ULP-D was hired on January 13, 2022, to provide direct care services to residents of the facility. ULP-D's employee record lacked documentation of a cleared background study. Review of NetStudy 2.0 on August 14, 2024, at 10:26 a.m., indicated a background study for ULP-D was submitted under a COVID-19 waiver, which expired December 31, 2022. A complete background study had not been submitted for ULP-D after the waivered study expired. On August 14, 2024, at 10:30 a.m., licensed assisted living director (LALD)-A stated ULP-D was employed by the licensee and worked full-time on the night shift (11:00 p.m., to 7:00 a.m.,). LALD-A stated ULP-D provided independent direct resident cares during their shift, worked alone and was not under direct supervision by another employee. LALD-A stated there was no background study clearance letter in ULP-D's employee record. The licensee's Recruitment and Hiring policy dated February 15, 2022, indicated in accordance with applicable state and federal regulations, the licensee would assure all persons were	01290		

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01290	Continued From page 40 appropriately screened prior to employment. Criminal Background Checks would be submitted to Minnesota DHS following the step-by-step procedures established by DHS. The director or designee would be responsible for initiating the criminal background study for new employees. NetStudy 2.0 (or current version) would be used for the background check. The employee would be directed to locations established by DHS to obtain fingerprint scans and the background study would be maintained in the employee's personnel file. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE	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	01370		

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01370	Continued From page 41 perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and competency evaluations included all the required training for one of two employees (unlicensed personnel (ULP)-C). 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:	01370		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34608	A. BUILDING: _____ B. WING _____	08/19/2024

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01370	Continued From page 42 ULP-C was re-hired on January 3, 2023, to provide direct care services to residents of the facility. On August 14, 2024, at 2:39 p.m., the surveyor observed ULP-C administering R2's Novolog (rapid-acting) insulin. ULP-C's s employee record included Comprehensive Home Care Orientation Training and Competencies completed from ULP-C's previous employment dated December 6, 2019; however, ULP-C's record did not include evidence ULP-C received the following required training and/or competencies after ULP-C left employment for a few years and was rehired under the licensee's assisted living license in 2023 to include: -documentation of requirements for all services; -reports of changes in the client's condition to the supervisor designated by the facility; -maintenance of a clean and safe environment -appropriate and safe techniques in personal hygiene and grooming, including: -hair care and bathing; -care of teeth and gums, and oral prosthetic devices; -care and use of hearing aids; and -dressing and assisting with toileting; -training on the prevention of falls for providers working with the elderly or individuals at risk of falls; -standby assistance techniques and how to perform them; -medication, exercise, and treatment reminders; -basic nutrition, meal preparation, food safety, and assistance with eating; -preparation of modified diets as ordered by a licensed health professional; -communication skills that include preserving the	01370		

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01370	Continued From page 43 dignity of the client and showing respect for the client and the client's preferences, cultural background, and family; -awareness of confidentiality and privacy; -understanding appropriate boundaries between staff and clients and the client's family; -procedures to utilize in handling various emergency situations; and -awareness of commonly used health technology equipment and assistive devices. On August 15, 2024, at 8:41 a.m., licensed assisted living director (LALD)-A stated ULP-C was previously hired in 2019, and stopped working for the provider for a few years and was rehired under the providers assisted living licensee on July 3, 2023. LALD-A stated she was unable to find documentation in ULP-C's employee record indicating ULP-C had received the required training and demonstrated competencies noted in the areas above when ULP-C was rehired by the licensee. The licensee's Staff Competency policy dated February 15, 2022, indicated all residents would receive quality service delivered by staff who were educated and competent in the delivery assisted living services. The licensee was committed to meeting or exceeding current practice standards. Training and competency evaluations for all unlicensed personnel include the following. Unlicensed personnel may not work for the licensee until they have successfully passed the written (at 80%) and demonstration competency evaluation in the following areas: -documentation requirements for all services provided; -reports of changes in the resident's condition to the supervisor designated by the assisted living provider;	01370		

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01370	Continued From page 44 -basic infection control, including blood-borne pathogens; -maintenance of a clean and safe environment; -appropriate and safe techniques in personal hygiene and grooming, including hair care and bathing; care of teeth, gums and oral prosthetic devices; care and use of hearing aids; and dressing and assisting with toileting. -training on the prevention of falls for providers working with the elderly or those at risk of falls; -standby assistance techniques and how to perform them; -medication, exercise and treatment reminders; -basic nutrition, meal preparation and preparation of modified diets as ordered by a licensed health professional, food safety and assistance with eating; -communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background and family; -awareness of confidentiality and privacy; -understanding appropriate boundaries between staff, residents and the resident's family; and -procedures to utilize in handling various emergency situations Awareness of commonly used health technology equipment and assistive devices. 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	01380		

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01380	Continued From page 45 providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and competency evaluations included all the required training for one of two employees (unlicensed personnel (ULP)-C). 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-C was re-hired on January 3, 2023, to provide direct care services to residents of the facility.	01380		

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01380	Continued From page 46 On August 14, 2024, at 2:39 p.m., the surveyor observed ULP-C monitor R2's blood glucose (sugar) with the FreeStyle Libre monitor (measures blood glucose through a sensor) and administer R2's Novolog (rapid-acting) insulin. ULP-C's s employee record included Comprehensive Home Care Orientation Training and Competencies completed from ULP-C's previous employment dated December 6, 2019; however, ULP-C's record did not include evidence ULP-C was retrained and received the following required training and/or competencies after ULP-C left employment for a few years and was rehired under the licensee assisted living license in 2023 to include: -observing, reporting, and documenting resident status; -basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; -reading and recording temperature, pulse, and respirations of the resident; -recognizing physical, emotional, cognitive, and developmental needs of the client; -safe transfer techniques and ambulation; -range of motioning and positioning; -administering medications or treatments as required; and -other RN/professionally delegated tasks (i.e., monitor vital signs, catheter or stoma care, Broda chair, mechanical lifts). On August 15, 2024, at 8:41 a.m., licensed assisted living director (LALD)-A stated ULP-C was previously hired in 2019, and stopped working for the provider for a few years and was rehired under the providers assisted living licensee on July 3, 2023. LALD-A stated she was	01380		

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01380	Continued From page 47 unable to find documentation in ULP-C's employee record indicating ULP-C received the required training and demonstrated competencies in the topics noted above when ULP-C was rehired by the licensee. The licensee's Staff Competency policy dated February 15, 2022, indicated all residents would receive quality service delivered by staff who were educated and competent in the delivery assisted living services. The licensee was committed to meeting or exceeding current practice standards. Training and competency evaluations for all unlicensed personnel include the following. Unlicensed personnel may not work for the licensee until they have successfully passed the written (at 80%) and demonstration competency evaluation in the following areas: -documentation requirements for all services provided; -reports of changes in the resident's condition to the supervisor designated by the assisted living provider; -basic infection control, including blood-borne pathogens; -maintenance of a clean and safe environment; -appropriate and safe techniques in personal hygiene and grooming, including hair care and bathing; care of teeth, gums and oral prosthetic devices; care and use of hearing aids; and dressing and assisting with toileting. -training on the prevention of falls for providers working with the elderly or those at risk of falls; -standby assistance techniques and how to perform them; -medication, exercise and treatment reminders; -basic nutrition, meal preparation and preparation of modified diets as ordered by a licensed health professional, food safety and assistance with eating;	01380		

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01380	Continued From page 48 -communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background and family; -awareness of confidentiality and privacy; -understanding appropriate boundaries between staff, residents and the resident's family; and -procedures to utilize in handling various emergency situations Awareness of commonly used health technology equipment and assistive devices. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380		
01460 SS=F	144G.63 Subdivision 1 Orientation of staff and supervisors All staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. The orientation may be incorporated into the training required under subdivision 5. The orientation need only be completed once for each staff person and is not transferable to another facility. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure staff providing and supervising direct services completed orientation to assisted living facility licensing requirements and regulations before providing services for one of two employees (clinical nurse supervisor (CNS)-B). This had the	01460		

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01460	Continued From page 49 potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on August 13, 2024, at 11:41 a.m., licensed assisted living director (LALD)-A stated the licensee was aware of required contents for an employee record. CNS-B had a hire date of May 31, 2024, to supervise and provide assisted living services to the licensee's residents. On August 14, 2024, during the course of the survey, the surveyor observed CNS-B provide care and services to the licensee's residents. CNS-B's employee record lacked orientation to assisted living requirements at the time of hire to include: -an overview of chapter 144G.08 through 144G.93; -an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; -handling of emergencies and use of emergency services; -compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting	01460		

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01460	Continued From page 50 Center (MAARC); -the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; -the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; -handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; -consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and -a review of the types of assisted living services the employee will be providing and the facility's category of licensure. On August 15, 2024, at 7:59 a.m., LALD-A stated CNS-B had not completed any training including the required orientation to assisted living licensing and requirements. LALD-A was unable to provide a reason why CNS-B had not completed the required orientation to assisted living training. The licensee's Personnel Records policy dated February 15, 2022, indicated a personnel record would be developed for each staff member upon hire and include documentation of orientation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01460		

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01470	Continued From page 51	01470		
01470 SS=E	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff 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	01470		

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01470	Continued From page 52 subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure staff providing services completed an orientation to assisted living facility licensing requirements and regulations before providing services for two of two employees (unlicensed personnel (ULP)-C, ULP-E). 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 included:	01470		

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01470	Continued From page 53 ULP-C ULP-C was hired on January 3, 2023, to provide direct care services to residents of the facility. On August 14, 2024, at 2:39 p.m., the surveyor observed ULP-C administering R2's Novolog (rapid-acting) insulin. ULP-E ULP-E was hired June 16, 2023, to provide direct care services to residents of the facility. On August 15, 2024, at 8:06 a.m., the surveyor observed unlicensed personnel ULP-E administering R2's Novolog insulin. ULP-C and ULP-E's employee record indicated ULP-C and ULP-E completed orientation to home care training; however, ULP-C and ULP-E's records lacked evidence of completing the following assisted living orientation 144G requirement topics before providing assisted living services to the licensee's residents: -an overview of the 144G statutes; -assisted living Bill of Rights; -review of types of Assisted Living services the employee will provide and provider's scope of license; -principles of person-centered planning/service delivery; and -hearing loss (optional). On August 15, 2024, at 8:41 a.m., licensed assisted living director (LALD)-A stated ULP-C was previously hired in 2019, and stopped working for the provider for a few years and was rehired under the providers assisted living licensee on July 3, 2023. LALD-A stated she was unable to find documentation in ULP-C's	01470		

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01470	Continued From page 54 employee record indicating ULP-C had received the required assisted living training noted above when ULP-C was rehired by the licensee. At 10:45 a.m., LALD-A stated ULP-E's Staff Orientation Outline and Sign-Off sheet did not indicate ULP-E completed the required orientation to assisted living content noted above. The licensee's Personnel Records policy dated February 15, 2022, indicated a personnel record would be developed for each staff member upon hire and include documentation of orientation. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01470		
01490 SS=F	144G.63 Subd. 4 Training required relating to dementia All direct care staff and supervisors providing direct services must demonstrate an understanding of the training specified in section 144G.64. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the required amount of dementia care training was completed in the required time frame in accordance with 144G.64 for three of three employees (clinical nurse supervisor (CNS)-B, unlicensed personnel (ULP)-C, ULP-E). 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	01490		

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01490	Continued From page 55 resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: CNS-B CNS-B was hired May 31, 2024, to provide supervision and direct care services for the licensee's residents. On August 14, 2024, during the course of the survey, the surveyor observed CNS-B provide care and services to the licensee's residents. ULP-C ULP-C was hired on January 3, 2023, to provide direct care services to residents of the facility. On August 14, 2024, at 2:39 p.m., the surveyor observed ULP-C administering R2's Novolog (rapid-acting) insulin. ULP-E ULP-E was hired June 16, 2023, to provide direct care services to residents of the facility. On August 15, 2024, at 8:06 a.m., the surveyor observed unlicensed personnel ULP-E administering R2's Novolog insulin. CNS-B, ULP-C, ULP-E's records lacked documentation they completed at least eight hours of initial dementia care training on required topics within 120 working hours, including: -an explanation of Alzheimer's disease and other dementia;	01490		

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01490	Continued From page 56 -assistance with activities of daily living; -problem solving with challenging behaviors; -communication skills; and -person-centered planning and service delivery. On August 15, 2024, at 7:59 a.m., LALD-A stated CNS-B had not completed any training courses including the required dementia care training noted above. At 8:41 a.m., LALD-A stated ULP-C was previously hired in 2019, and stopped working for the provider for a few years and was rehired under the providers assisted living licensee on July 3, 2023. LALD-A stated she was unable to find documentation in ULP-C's employee record indicating ULP-C had completed the required dementia training when ULP-C was rehired by the licensee. At 10:45 a.m., LALD-A stated she was unable to find documentation in ULP-E's employee record ULP-E completed the required dementia training noted above. The licensee's Personnel Records policy dated February 15, 2022, indicated a personnel record would be developed for each staff member upon hire and include documentation of orientation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01490		
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	01530		

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01530	Continued From page 57 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; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure three of three employees (clinical nurse supervisor (CNS)-B, unlicensed personnel (ULP)-C, ULP-E) received the required amount of dementia care training in the required time frame. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	01530		

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01530	Continued From page 58 The findings include: CNS-B CNS-B was hired May 31, 2024, to provide supervision and direct care services for the licensee's residents. On August 14, 2024, during the course of the survey, the surveyor observed CNS-B provide care and services to the licensee's residents. ULP-C ULP-C was hired on January 3, 2023, to provide direct care services to residents of the facility. On August 14, 2024, at 2:39 p.m., the surveyor observed ULP-C administering R2's Novolog (rapid-acting) insulin. ULP-E ULP-E was hired June 16, 2023, to provide direct care services to residents of the facility. On August 15, 2024, at 8:06 a.m., the surveyor observed unlicensed personnel ULP-E administering R2's Novolog insulin. CNS-B's record lacked documentation CNS-B completed at least eight hours of initial dementia care training on required topics within 120 hours of start date; furthermore, ULP-C and ULP-E's records lacked documentation ULP-C and ULP-E completed at least eight hours of initial dementia care training within 160 hours of start date. On August 15, 2024, at 7:59 a.m., LALD-A stated CNS-B had not completed any training courses including eight hours of initial dementia care training within 120 hours of start date. At 8:41	01530		

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01530	Continued From page 59 a.m., LALD-A stated ULP-C was previously hired in 2019 and stopped working for the provider for a few years and was rehired under the providers assisted living licensee on July 3, 2023. LALD-A stated she was unable to find documentation in ULP-C's employee record indicating ULP-C completed eight hours of initial dementia training when ULP-C was rehired by the licensee. At 10:45 a.m., LALD-A stated she was unable to find documentation in ULP-E's employee record ULP-E completed the required eight hours initial dementia training noted within 160 hours of start date. The licensee's Personnel Records policy dated February 15, 2022, indicated a personnel record would be developed for each staff member upon hire and include documentation of orientation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01530		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for	01640		

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01640	Continued From page 60 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 was revised to reflect the current services provided for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2's diagnoses included schizophrenia and diabetes. On August 14, 2024, at 2:39 p.m., the surveyor observed unlicensed personnel (ULP)-C monitor R2's blood sugar with the Libre monitor (measures glucose through a sensor) and administer R2 12 units of Novolog (rapid-acting) insulin.	01640		

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01640	Continued From page 61 R2's August 2024 Medication Administration Report (MAR), indicated R2 received blood glucose monitoring three times a day. R2's Service Plan dated July 22, 2022, did not include R2 received blood glucose monitoring three times a day. On August 14, 2024, at 1:02 p.m., clinical nurse supervisor (CNS)-B verified R2 received blood glucose monitoring three times a day and R2's service plan did not include blood glucose monitoring services. The licensee's Service Plan policy, date February 15, 2022, indicated the service plan would include a description of services to be provided, the frequency of each service, fees for service, and identification of the staff or categories of staff who would provide the services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01640		
01750 SS=I	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and	01750		

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01750	Continued From page 62 (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the registered nurse (RN) instructed unlicensed personnel (ULP)-C, ULP-D) in the proper methods to administer medications, and the unlicensed personnel had demonstrated the ability to competently follow the procedures for administering medications. This had the potential to affect all residents receiving assisted living services. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). This practice resulted in an immediate correction order on August 15, 2024. The findings include: On August 13, 2024, at 12:23 p.m., during entrance conference, licensed assisted living director (LALD)-A stated the licensee employed a new part-time RN who completed resident assessments and was responsible for training and completing staff competency evaluations. R2's diagnoses included schizophrenia and diabetes.	01750		

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01750	Continued From page 63 R2's Service Plan dated July 22, 2022, indicated R2 received medication administration by the licensee. R2's record lacked current annual physician orders for prescribed medications and treatments. R2's August 2024 Medication Administration Report (MAR) indicated R2 received Novolog Flex-pen U-100 insulin to inject 12 units under the skin three times a day with meals and to see drug leaflet, and Lantus Solostar U-100 insulin (long-acting) inject 36 units at bedtime under the skin, see drug leaflet; however, R2's (MAR) did not include directions to prime the insulin pens two units prior to dialing insulin dose and administering. ULP-C ULP-C was had a hire date of July 3, 2023, to provide direct care services to the residents of the assisted living facility. On August 14, 2024, at 2:39 p.m., the surveyor observed ULP-C gather R2's Novolog prefilled insulin pen (rapid-acting insulin), dial 12 units of insulin, and inject into R2's left upper arm. ULP-C did not prime the Novolog insulin pen two units before dialing the prescribed dose and administering R2's insulin. Immediately following the insulin administration, ULP-C stated he was not trained to dial two units of insulin prior to dialing the prescribed dose. ULP-C's training record included documentation of Comprehensive Home Care Orientation Training and Competencies for medication administration from ULP-C's previous	01750		

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01750	Continued From page 64 employment dated December 6, 2019; however, ULP-C's record did not include evidence ULP-C was re-trained and demonstrated competency to the RN for medication administration after ULP-C was re-hired on July 3, 2023. On August 15, 2024, at 8:41 a.m., LALD-A stated ULP-C was previously hired in 2019, and stopped working for the provider for a few years and was rehired under the providers assisted living licensee on July 3, 2023. LALD-A stated she was unable to find documentation in ULP-C's employee record indicating ULP-C had received training and demonstrated competencies to the RN in medication administration when ULP-C was rehired by the licensee. ULP-E ULP-E was hired June 16, 2023, to provide direct care services to residents of the assisted living facility. On August 15, 2024, at 8:06 a.m., the surveyor observed ULP-E administering R3's scheduled morning medications. On August 15, 2024, at 8:13 a.m., the surveyor observed ULP-E gather R2's Novolog prefilled insulin pen, dial 12 units of insulin, and inject into R2's right upper arm. ULP-E did not prime the Novolog insulin pen two units before dialing the prescribed dose and administering R2's insulin. ULP-E's employee record lacked evidence ULP-E completed training and demonstrated competency to the RN in medication administration. On August 15, 2024, at 10:57 a.m., ULP-E stated she was trained by the previous nurse upon hire	01750		

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01750	Continued From page 65 on medication administration and her training was all recorded on paper. On August 15, 2024, at 1:11 p.m., the surveyor requested written instructions on insulin administration and LALD-A stated she was unaware if the licensee had a written policy or procedure for administering insulin. LALD-A stated she was trained by the RN on medication administration including insulin and was unaware about priming insulin before dialing the prescribed dose. On August 15, 2024, at 1:28 p.m., ULP-C obtained the manufacture directions from R2's Novolog insulin box located in the locked medication refrigerator and reviewed with surveyor. The manufacturer's instructions for Novolog insulin flex pens dated October 2023, indicated to prime the Novolog insulin pen two units before each injection to ensure proper dose. ULP-C stated she was unaware she was supposed to prime the insulin pen two units prior to dialing the insulin dose and administering. The licensee's Delegation of Assisted Living Tasks policy dated February 15, 2022, indicated the clinician (Registered Nurse or licensed health professional) RN was responsible for appropriately delegating tasks to the staff who are competent and possess the knowledge and skills consistent with the complexity of the tasks in accordance with the appropriate Minnesota Practice Act. The clinician would instruct the home health aide in the proper methods to perform the procedure, provide written instructions specific to the resident and the home health aide would demonstrate to the clinician competency in the procedure and document in his/her personnel file.	01750		

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01750	Continued From page 66 No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	01750		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were administered per the manufacturer's instructions for one of two residents (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).	01760		

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01760	Continued From page 67 The findings include: R2's diagnosis included diabetes type II. R2's Service Plan dated July 22, 2022, indicated R2 received medication assistance services. R2's record included electronic prescriptions for Novolog Flex pen (rapid-acting) insulin 12 units three times a day with meals. R2's August 2024 Medication Administration Report (MAR) indicated R2 was scheduled and received Novolog Flex pen insulin 12 units three times a day. On August 14, 2024, at 2:39 p.m., the surveyor observed unlicensed personnel (ULP)-C dial up 12 units of Novolog insulin and administer into R2's left upper arm. ULP-C did not prime the Novolog insulin pen two units prior to dialing prescribed dose and administering to R2. On August 15, 2024, at 8:06 a.m., the surveyor observed ULP-E dial up 12 units of Novolog insulin and administer into R2's right upper arm. ULP-E did not prime the Novolog insulin pen two units prior to dialing prescribed dose and administering to R2. On August 15, 2024, at 8:41 a.m., ULP-E stated she was trained by the previous registered nurse to prime insulin pens two units before dialing prescribed dose. On August 15, 2024, at 1:11 p.m., the surveyor requested written instructions on insulin administration and LALD-A stated she was unaware if the licensee had a written policy or	01760		

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01760	Continued From page 68 procedure for administering insulin. LALD-A stated she was trained by the previous RN on medication administration including insulin and was unaware about priming insulin before dialing the prescribed dose. The licensee's Medication Administration policy dated February 15, 2022, indicated the registered nurse may delegate medication administration to an unlicensed staff and the registered nurse would prepare written instructions for the ULP in proper methods to administer medications with respect to each resident. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01790 SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may	01790		

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01790	Continued From page 69 delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the	01790		

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	34608	A. BUILDING: _____ B. WING _____	08/19/2024

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01790	Continued From page 70 doses of each returned medication. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure two of unlicensed personnel (ULP-C , ULP-E) were trained and had demonstrated competency to prepare and give medications for residents having unplanned time away. In addition, the licensee failed to ensure the registered nurse (RN) developed written procedures with all the required content for ULP providing medications for residents having unplanned time away when the licensed nurse was not available. 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: ULP-C ULP-C was hired on January 3, 2023, to provide direct care services to residents of the facility which include medication administration. On August 14, 2024, at 2:39 p.m., the surveyor observed ULP-C administering R2's Novolog (rapid-acting) insulin. ULP-E ULP-E was hired June 16, 2023, to provide direct care services to residents of the facility which	01790		

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01790	Continued From page 71 include medication administration. On August 15, 2024, at 8:31 a.m., the surveyor observed ULP-E administering R2's scheduled morning medications. ULP-C and ULP-E's employee records lacked evidence to indicate ULP-C and ULP-E had been trained and had demonstrated competency to provide medications to residents for unplanned times away from home. The licensee's Medication Management Plan for Residents Away from Home policy dated August 1, 2021, indicated for unplanned times away from home for temporary periods when an adequate medication supply cannot be obtained from the pharmacy or set up by the registered nurse in a timely manner, the registered nurse may delegate to an unlicensed personnel (home health aide) to provide the medications based on the following: -the registered nurse had trained the home health aide and determine the home health aide competency to follow the procedures for giving medications to residents; -the registered nurse has instructed the home health aide to ensure that all appropriate precautions are taken; -the registered nurse would had developed written procedures/protocols for the home health aide, including any special instructions or procedures regarding controlled substances (refer also to Protocol for residents away from home) including: -the type of container(s) to be used for the medications appropriate to the facility's medication system; -how the container or container(s) should be labeled; -written information about the medications to	01790		

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01790	Continued From page 72 provided; -documenting requirements: date the medications were provided, who received the medications, who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; -how the RN shall be notified that medications were provided and whether the RN should be notified before the medications are given to the client or the client's representative; -upon return to the facility, the home health aide must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication; and -the RN must review the setup of mediation and documentation to ensure that the issuance of medications by the home health aide and the return of any unused medications were handled appropriately. On August 15, 2024, at 10:45 am, licensed assisted living director (LALD)-A stated the licensee had a policy for planned and unplanned time away; however, was unsure if the RN had developed a written procedure for unplanned time away. LALD-A stated she was unable to find documentation in ULP-C and ULP-E's employee records to indicate ULP-C and ULP-E were trained and demonstrated competency in preparing medications for residents when away from the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790		

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01820	Continued From page 73	01820		
01820 SS=D	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure current written or electronically recorded prescriptions were obtained for one of two residents (R3) who received medication management services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R3's diagnoses included bipolar, anxiety, hallucinations, agitation, paranoia, aggressiveness, and post traumatic stress disorder (PTSD). R3's Service Plan dated March 24, 2024, indicated R3 received medication assistance services. On August 15, 2024, at 8:06 a.m., the surveyor observed unlicensed personnel administering R3's scheduled morning medications.	01820		

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01820	Continued From page 74 R3's August 2024 Medication Administration Report (MAR) indicted R3 was scheduled and received the following medications: -aspirin (heart health) 81 milligrams (mg) daily; -lisinopril (for high blood pressure) 10 mg daily; -metoprolol succinate (for high blood pressure) 25 mg one-half tablet daily; -rosuvastatin (for high cholesterol) 40 mg daily; and -vitamin D3 (supplement) 1,000 units daily. R3's record lacked signed prescription orders for R3's medications noted above. On August 14, 2024, at 9:38 p.m., clinical nurse supervisor (CNS)-B stated she was unsure why R3's record did not have prescriber orders for medications or how the previous nurse obtained medication orders. CNS-B stated she recently sent R3's provider a medication list for signed orders. The surveyor requested a copy of the fax CNS-B sent to R3's provider and did not receive. The licensee's Medication Orders policy dated February 15, 2022, indicted the licensee would maintain a current written or electronically recorded prescription for all prescribed medications managed for the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		
01830 SS=D	144G.71 Subd. 14 Renewal of prescriptions Prescriptions must be renewed at least every 12 months or more frequently as indicated by the	01830		

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01830	Continued From page 75 assessment in subdivision 2. Prescriptions for controlled substances must comply with chapter 152. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to renew prescriptions at least every 12 months for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During entrance conference on August 13, 2024, at 11:41 a.m., licensed assisted living director (LALD)-A stated the licensee provided medication management services to the residents at the facility. R2's diagnoses included schizophrenia and diabetes type II. R2's Service Plan dated July 22, 2022, indicated R2 received medication assistance services. On August 14, 2024, at 2:39 p.m., the surveyor observed unlicensed personnel (ULP)-C administering R2's scheduled afternoon insulin. On August 15, 2024, at 8:31 a.m., the surveyor	01830		

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01830	Continued From page 76 observed ULP-E administering R2's scheduled morning medications. R2's record included electronic prescriptions for the following medications: -atorvastatin (high cholesterol) 40 mg daily dated June 15, 2023; -lisinopril (for high blood pressure) 2.5 milligrams (mg) daily dated June 15, 2023 -metformin (for diabetes) 1000 mg one tablet twice a day with meals dated June 15, 2023; -Novolog Flex pen insulin (rapid-acting) inject 12 units three times a day dated June 15, 2023; and -Lantus Solostar insulin (long-acting) inject 36 units at bedtime dated June 15, 2023. R2's August 2024 Medication Administration Record (MAR) indicated R2 was scheduled and received the following medications: -atorvastatin 80 mg one-half tablet at bedtime; -lisinopril 2.5 milligrams (mg) in the morning; -metformin 1000 mg one tablet twice a day with meals; -Novolog Flex pen insulin inject 12 units under the skin three times a day; and -Lantus Solostar insulin inject 36 units under the skin at bedtime; R2's record lacked prescriber orders renewed at least every 12 months for the medications noted above. On August 14, 2024, at 2:04 a.m., clinical nurse supervisor (CNS)-B stated R2's record did not include annual prescriber orders for medications, only electronic prescriptions and CNS-B recently faxed R2's provider to obtain annual medication orders. The licensee's Prescriber's Orders policy dated	01830		

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01830	Continued From page 77 February 15, 2022, indicated medication orders would be renewed at least every year or when changes occur. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01830		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure refrigerated medications were maintained at manufacturer recommended temperatures by failing to monitor and document medication refrigerator temperatures for one of one medication refrigerator. 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:	01880		

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01880	Continued From page 78 During entrance conference on August 13, 2024, at 11:41 a.m., licensed assisted living director (LALD)-A stated the license provided secured medication storage. At 1:15 p.m., the surveyor requested three months of recorded medication refrigerator temperatures and LALD-A stated she was unsure if the temperatures were being monitored and would have to ask clinical nurse supervisor (CNS)-B. On August 13, 2024, at 3:26 p.m., the surveyor observed the medication refrigerator with unlicensed personnel (ULP)-C. ULP-C stated he was unsure who was monitoring refrigerator temperatures and verified there was no thermometer in the medication refrigerator and confirmed the following medications being stored: -six unopened boxes of R1's Lantus Solostar (long-acting) prefilled insulin pens containing five insulin pens per box and 11 single Lantus Solostar prefilled insulin pens; and -two unopened boxes of R1's Novolog Flexpen (rapid-acting) prefilled insulin pens containing five insulin pens per box and seven single Novolog Flexpen prefilled insulin pens. On August 14, 2024, at 9:28 a.m., LALD-A stated the licensee had not been monitoring medication refrigerator temperatures and was unaware of the requirement. The manufacturer's instructions for Lantus Solostar insulin pen dated June 2022, indicated to store unopened Lantus insulin in the refrigerator at 36 to 46 degrees Fahrenheit (F) and do not freeze. The manufacturer's instructions for Novolog Flex insulin pen dated November 2021, indicated to store unopened Novolog in the refrigerator at 36	01880		

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01880	Continued From page 79 to 46 degrees F and do not freeze. The licensee's Storage/Control of Medications policy, dated August 1, 2021, indicated when medications are managed and stored by the licensee, medications would be kept securely locked and stored per manufacturer directions and only staff would have access to stored medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were maintained bearing the original prescription label with information regarding the direction for use, medication name, medication dosage, resident's name, and the pharmacy in which it had been issued for one of two residents (R2) who received medication storage by the licensee. 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	01890		

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01890	Continued From page 80 resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2's diagnoses included schizophrenia and diabetes. R2's Service Plan dated July 22, 2022, indicated R2 received medication administration by the licensee. R2's record included electronic prescriptions dated June 15, 2023, to include Novolog Flex-pen (rapid-acting) insulin 12 units three times a day and Lantus Solostar (long-acting) insulin 36 units at bedtime. R2's record lacked current annual physician orders for prescribed medications and treatments. R2's August 2024 Medication Administration Report (MAR) indicated R2 received Novolog Flex-pen U-100 insulin to inject 12 units under the skin three times a day with meals, and Lantus Solostar U-100 insulin inject 36 units at bedtime under the skin. On August 14, 2024, at 2:39 p.m., the surveyor observed unlicensed personnel (ULP)-C gather R2's Novolog prefilled insulin pen insulin, dial 12 units of insulin, and inject into R2's left upper arm. R2's Novolog insulin lacked an original prescription label with information regarding the direction for use, medication name, medication	01890		

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01890	Continued From page 81 dosage, resident's name, and the pharmacy in which it had been issued. Immediately following R2's insulin administration, ULP-C verified R2's insulin pens did not have individual prescription labels on each insulin pen and stated the prescription label was only on the box of insulin located in the medication refrigerator. On August 14, 2024, at 3:28 p.m., licensed assisted living director (LALD)-A verified R2's Novolog and Lantus insulin pens did not have prescription labels of each individual insulin pens and would need to contact the pharmacy. The licensee's Storage/Control of Medications policy dated August 1, 2021, indicated stored medications should be clearly labeled with the following content: -prescription number and name of medication; -strength and quality; -expiration date for time-dated drugs; -directions for use; -resident's name; -prescriber's name; -date issued; and -name and address of licensed pharmacy issuing the medication. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01910 SS=F	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer	01910		

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01910	Continued From page 82 part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document in the resident record the disposition of the medications as required for one of one resident (R1) upon discharge. 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 schizophrenia, bipolar and post-traumatic stress disorder (PTSD). R1's Service Plan dated April 4, 2024, indicated	01910		

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01910	Continued From page 83 R1's services included medication management, behavioral management, laundry, housekeeping, and meals. R1's undated Individualized Medication Management Plan indicated R1 received medication administration by facility staff, the facility nurse was responsible for monitoring medication supplies and refills, and R1's medications were stored in a locked medication cart. R1's Medication Administration Report (MAR) dated May 1, 2024 through May 29, 2024, indicated R1 was scheduled and received the following medications: -atorvastatin 10 milligrams (mg) (used for high cholesterol) daily; -benzotropine 0.5 mg (depressant) one tablet twice a day; -fluoxetine 40 mg (antidepressant) two capsules daily; -prazosin 1 mg (used to treat high blood pressure, PTSD) at bedtime; and -risperidone 4 mg (used to treat schizophrenia) one tablet twice a day; R1's Discharge Summary dated May 24, 2024, indicated R1 was admitted April 6, 2024, and discharged May 24, 2024. R1 received assistance with medication management, scheduling appointments, social activities, and meals. R1's Discharge Summary boxes were blank to indicate whether R1 received his belonging and/or medications. R1's record lacked documentation for the disposition of the medications noted above to include the medication's name, strength, prescription number as applicable, quantity, to	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34608	A. BUILDING: _____ B. WING _____	08/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHT LIVING LLC	7309 ZANE AVENUE NORTH BROOKLYN PARK, MN 55443

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01910	Continued From page 84 whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. On August 14, 2024, at 10:23 a.m., clinical nurse supervisor (CNS)-B provided a blank Medication Disposition Form and stated that was the form the licensee used when documenting the disposition of resident medications. CNS-B verified the Medication Disposition Form did not include an area to document the medication prescription number, and would be missing for all discharged residents. On August 15, 2024, at 2:30 p.m., licensed assisted living director (LALD)-A stated R1 left the facility on his own and went to a detox center and never retruned to the facility. LALD-A stated the licensee did not document the disposition of R1's medications because R1 did not have any medications at the time R1 left the facility. LALD-A verified R1's May 2024 MAR indicated R1 received medications on May 24, 2024, the day R1 left the facility. LALD-A stated she did not document in R1's records any information regarding the status of R1's medications at the time of R1's discharge. The licensee's Disposition and Disposal of Medications policy dated February 15, 2022, indicated unused portions of current medications being managed by the facility would be given to the resident or responsible party when the resident's service plan ends, medication management services are no longer provided under the service plan or upon discharge; and a note regarding this is placed in the clinical record. The licensee would document the following information in the clinical record: -name, strength and prescription number of	01910		

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01910	Continued From page 85 medication, as applicable; -quantity; -method of disposition or to whom the medications were given; -name(s)/signature(s) of staff or other individuals involved in disposition; and -if applicable, to whom the medications were given. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
01950 SS=D	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and This MN Requirement is not met as evidenced by:	01950		

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01950	Continued From page 86 Based on observation, interview, and record review, the licensee failed to ensure instructions, specified in writing for each resident, and documented those instructions in the resident's record for one of one resident (R2) who received blood glucose monitoring. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2's diagnoses included schizophrenia and diabetes. On August 14, 2024, at 2:39 p.m., the surveyor observed unlicensed personnel (ULP)-C monitor R2's blood sugar with the FreeStyle Libre monitor (measures glucose through a sensor). R2's August 2024 Medication Administration Report (MAR), indicated R2 received blood glucose monitoring three times a day. R2's record did not include blood glucose parameters of when to notify the nurse or provider. On August 14, 2024, at 1:02 p.m., clinical nurse supervisor (CNS)-B stated R2 did not have blood glucose parameters set of when to notify the nurse or provider because R2's provider had not put any blood glucose parameters in place.	01950		

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01950	Continued From page 87 The licensee's Treatment and Therapy Management Plan policy dated February 15, 2022, indicated the licensee would prepare an individualized treatment or therapy management plan for each resident receiving orders or prescribed treatments or therapy services which addresses: -procedures for notifying the registered nurse or licensed health professional when a problem arises with treatment or therapy services. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950		
01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure written or electronically recorded orders were obtained for one of one resident (R2) who had treatments managed by the provider. This practice resulted in a level two violation (a violation that did not harm a resident's health or	01970		

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01970	Continued From page 88 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2's diagnoses included schizophrenia and diabetes. R2's Service Plan dated July 22, 2022, did not include R2 received blood glucose (sugar) monitoring by the licensee. R2's August 2024 Medication Administration Report (MAR), indicated R2 received blood glucose monitoring three times a day. On February 14, 2024, at 9:38 a.m., clinical nurse supervisor (CNS)-B stated she was responsible for changing R2's Freestyle Libre sensor (a sensor that monitors blood glucose levels) every two weeks. On August 14, 2024, at 1:02 p.m., CNS-B stated she was unable to find treatment orders for R2's blood glucose monitoring and recently faxed R2's provider to obtain treatment and medication orders and was awaiting for a return fax. On August 14, 2024, at 2:39 p.m., the surveyor observed unlicensed personnel (ULP)-C monitor R2's blood glucose with the Libre monitor. The licensee's Treatment and Therapy Management policy dated February 15, 2022, indicated the registered nurse (RN) or licensed	01970		

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01970	Continued From page 89 health professional would obtain orders or prescriptions for all treatments and therapies. The order would include the following elements: -resident name; -description of the treatment or therapy to be provided; -frequency; and -other pertinent information. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970		

Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF CONDITIONAL LICENSE

Electronically Delivered

September 20, 2024

Licensee
Bright Living LLC
7309 Zane Avenue North
Brooklyn Park, MN 55443

RE: Conditional License Number 417226
Health Facility Identification Number (HFID) 34608
Project Number(s) SL34608015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 19, 2024, for the purpose of assessing compliance with state licensing statutes. Based on the survey results you were found not to be in substantial compliance with the laws pursuant to Minnesota Statutes, Chapter 144G.

As a result, pursuant to Minn. Stat. § 144G.20, MDH is issuing a 90-day conditional license due to expire on **December 19, 2024**.

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

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

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

§ 144G.20.

MDH may assess fines based on the level and scope of the orders outlined below. The total amount of **potential** fines that may be assessed related to these correction orders is $6,500.00. **MDH is not imposing these fines against your license at this time.**

0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00
1290 - 144g.60 Subdivision 1 - Background Studies Required - $3,000.00
1750 - 144g.71 Subd. 7 - Delegation Of Medication Administration - $3,000.00

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 and immediately correct any reissued orders outlined on the state form; however, plans of correction are not required to be submitted for approval. **If corrections are not made, MDH may impose fines as described above and in accordance with Minnesota Statutes 144G.**

The correction order documentation should include the following:

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

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

A state correction order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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.

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

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

a. **No new substantiated maltreatment allegations:** If any new investigations begin in the conditional license period, and the allegations are substantiated, MDH may pursue additional enforcement actions up to and including immediate temporary suspension and revocation of the license.

b. **No new admissions:** Bright Living LLC will not admit any new residents under its conditional assisted living facility license until MDH removes the "no new admissions" condition. Bright Living LLC must provide the Department:

   i. A list of the names and birthdates of any individuals Bright Living LLC is currently in the process of admitting. These individuals will be able to continue the admittance process.

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

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

d. **Reports:** The RN consultant will provide MDH with regular reports at intervals specified by MDH. Reports will begin on a weekly basis until MDH notifies Bright Living LLC and the RN consultant about a change. Each report will be electronically submitted to Jessie Chenze, Surveyor Supervisor, State Evaluation Team, Health Regulation Division, at jessie.chenze@state.mn.us. Jessie Chenze can be reached at 218-332-5175 (office) with questions about reports. The content of the reports will include information such as:

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

e. **Monitoring visits:** MDH may make unannounced monitoring visits to assess the progress of Bright Living LLC to correct the violations cited during the survey as

well as to determine the overall practice of Bright Living LLC in meeting the needs of the people it serves. In addition, the Office of Ombudsman for Long-Term Care (OOLTC) may also make unannounced monitoring visits to determine the level of satisfaction of those people who receive licensed assisted living services. The OOLTC will share their findings with MDH.

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

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

RESULTS OF FOLLOW-UP EVALUATION DURING THE CONDITIONAL LICENSE PERIOD:
MDH will determine if Bright Living LLC is in substantial compliance based on the results of the follow up survey. MDH will make this determination within the 90-day conditional license period. If MDH determines Bright Living LLC is in substantial compliance on the follow up survey, MDH will remove the conditions from Bright Living LLC's assisted living facility license, and Bright Living LLC will correct any outstanding violations identified during the survey. If Bright Living LLC is not in substantial compliance on the follow-up survey, MDH may take additional enforcement action, up to and including immediate temporary suspension and revocation, as authorized by Minn. Stat. § 144G.20.

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

INFORMAL CONFERENCE
In accordance with Minn. Stat. § 144G.20, Subd. 20, the Commissioner of Health is authorized to hold a conference to exchange information, clarify issues, or resolve issues. The Department of Health staff would like to schedule a conference call with Bright Living LLC. Please contact Jessie Chenze directly at 218-332-5175 on or before Wednesday, September 25, 2024, to schedule the conference call.

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 Jessie Chenze directly at: 218-332-5175.

Sincerely,

Rick Michals

Rick Michals, J.D.
Executive Regional Operations Manager
Minnesota Department of Health
Health Regulation Division

JMD

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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: SL34608015-0 On August 13, 2024, through August 19, 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 two residents receiving services under the provider's Assisted Living Facility license. Immediate correction orders were identified on August 14 and August 15, 2024, for project SL34608015, tag identification 1290 and 1750 respectively, both issued at scopes and levels of widespread, level three (l).	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.	
0 100 SS=F	144G.10 Subdivision 1 License required (a)(1)Beginning August 1, 2021, no assisted living	0 100		

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0 100	Continued From page 1 facility may operate in Minnesota unless it is licensed under this chapter. (2) No facility or building on a campus may provide assisted living services until obtaining the required license under paragraphs (c) to (e). (b)The licensee is legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. Nothing in this chapter shall in any way affect the rights and remedies available under other law. (c) Upon approving an application for an assisted living facility license, the commissioner shall issue a single license for each building that is operated by the licensee as an assisted living facility and is located at a separate address, except as provided under paragraph (d) or (e). (d) Upon approving an application for an assisted living facility license, the commissioner may issue a single license for two or more buildings on a campus that are operated by the same licensee as an assisted living facility. An assisted living facility license for a campus must identify the address and licensed resident capacity of each building located on the campus in which assisted living services are provided. (e) Upon approving an application for an assisted living facility license, the commissioner may: (1) issue a single license for two or more buildings on a campus that are operated by the same licensee as an assisted living facility with dementia care, provided the assisted living facility for dementia care license for a campus identifies the buildings operating as assisted living facilities with dementia care; or (2) issue a separate assisted living facility with dementia care license for a building that is on a campus and that is operating as an assisted living facility with dementia care.	0 100		

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0 100	Continued From page 2 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to obtain accurate licensure when the licensee applied for licensure for a single residential dwelling, despite sharing one roof with adjoining town homes, without having an approved two-hour fire wall separating the three dwellings. 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 health facility identification (HFID 34608), a building, was located at 7309 Zane Avenue North, Brooklyn Park, MN, 55443, and shared two walls adjoining occupied residential townhomes under the same roof. During entrance conference on August 13, 2024, at 11:41 a.m., licensed assisted living director (LALD)-A stated the licensee was familiar with current minimum assisted living requirements. On August 13, 2024, at 1:19 p.m., the surveyor toured the facility with LALD-A and the engineer surveyor from the Minnesota Department of Health (MDH). During the tour, the surveyor observed the facility as part of multi-unit town	0 100		

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	34608	A. BUILDING: _____ B. WING _____	08/19/2024

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0 100	Continued From page 3 homes. Each unit of the town homes had a private entrance; however, all units shared an adjoining wall with another unit, under one roof. LALD-A stated the other town homes which the licensee shared a common wall were occupied by a private party. On August 13, 2024, at 3:15 p.m., the engineer surveyor from MDH informed LALD-A requirements of a two-hour separation fire wall between the town home units. LALD-A stated the licensee rented the town home from a private party and would have to reach out to the landlord to request information regarding the status of the shared walls. LALD-A stated the licensee was unaware of the requirement of needing an approved two-hour fire wall separating the town homes. The surveyor requested LALD-A to send documentation of a two-hour separation fire wall between the town home units no later than August 19, 2024, end of business day, however, additional documentation was never received from LALD-A. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 100		
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	0 250		

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0 250	Continued From page 4 license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4, or interferes with or impedes access by the Office of Ombudsman for Mental Health and Developmental Disabilities according to section 245.94, subdivision 1; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (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	0 250		

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0 250	Continued From page 5 performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the management officials who were in charge of the day-to-day operations; and responsible for the resident's assisted living services, understood all of the assisted living facility regulations. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During entrance conference on August 13, 2024, at 11:41 a.m., licensed assisted living director (LALD)-A stated the licensee was familiar with the assisted living regulations. 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 6 - I have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section] 144G.45 (opens in a new window), 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 (opens in a new window). - I have read and fully understand Minn. Stat. sect. 144G.80 (opens in a new window), 144G.81 (opens in a new window). and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22 (opens in a new window), my building(s) must comply with these sections if applicable. - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G (opens in a new window). - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659 (proposed and not final) (opens in a new window). - Reporting of Maltreatment of Vulnerable Adults (opens in a new window). - Electronic Monitoring in Certain Facilities (opens in a new window)." - "I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G (opens in a new window), and Minnesota Rules, chapter 4659 (proposed and not final) (opens in a new window), 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 f 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	0 250		

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0 250	Continued From page 7 required." - I attest to have all required policies and procedures of Minn. Stat. chapter 144G (opens in new window). and Minn. Rules chapter 4659 (proposed and not final) (opens in new window), in place upon licensure and to keep them current as applicable." Page six was electronically signed by LALD-A on May 7, 2024. The licensee had an assisted living license, effective July 1, 2024. The licensee failed to ensure the following policies and procedures were developed and/or implemented: - infection control practices; - orientation and training of staff; - handling complaints regarding staff or services provided by staff; - conducting initial and ongoing resident evaluations and assessments of resident needs: - conducting and handling background studies on employees; - medication and treatment management; and - delegation of tasks by registered nurses or licensed health professionals. As a result of the survey, the following correction orders were issued, 0100, 0250, 0460, 0470, 0480, 0510, 0650, 0660, 0680, 0690, 0720, 0780, 0800, 0810, 0970, 1290, 1370, 1380, 1460, 1470, 1490, 1530, 1640, 1710, 1750, 1760, 1790, 1820, 1830, 1880, 1890, 1910, 1950, 1970 which indicated the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.01 to 144G.95.	0 250		

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0 250	Continued From page 8 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21)	0 250		
0 460 SS=F	144G.41 Subdivision 1 Minimum requirements (5) provide a means for residents to request assistance for health and safety needs 24 hours per day, seven days per week; (6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract; (7) permit residents access to food at any time; (8) allow residents to choose the resident's visitors and times of visits; (9) allow the resident the right to choose a roommate if sharing a unit; (10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living facility must not lock a resident in the resident's unit; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide a means for residents to request assistance for health and safety needs 24 hours a day, seven days a week. This had the potential to affect all residents residing at the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 460		

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0 460	Continued From page 9 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: The licensee held an assisted living facility license and was licensed for a capacity of four residents, with a census of two residents residing in the facility. During entrance conference on August 13, 2024, at 11:41 a.m., licensed assisted living director (LALD)-A stated the license did not have a system in place for residents to summons staff for assistance. During the facility tour on August 13, 2024, at 1:43 p.m., with LALD-A, no call system was observed in resident rooms to summons staff. The licensee's Uniform Disclosure of Assisted Living Service and Amenities (UDALSA) dated May 13, 2022, indicated the licensee did not provide an emergency call system. No other information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 460		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at	0 470		

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0 470	Continued From page 10 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 observation, interview, and record review, the licensee failed to ensure the clinical nurse supervisor (CNS) reviewed the licensee's staffing plan to determine staffing levels to meet the needs of all residents at a minimum twice a year as required. In addition, the licensee failed to ensure the daily staffing schedule was posted in a central location. 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	0 470		

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0 470	Continued From page 11 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 finding include: The licensee held an assisted living facility license and was licensed for a census of four residents. During the facility tour on August 13, 2024, at 1:43 p.m., with licensed assisted living director (LALD)-A, the daily staffing schedule was not observed posted in the facility. LALD-A stated the staff schedule was usually posted on the bulletin board and did not know why the schedule was not posted. On August 14, 2024, at 12:00 p.m., clinical nurse supervisor (CNS)-B provided the licensee's staffing plan and policy. The licensee's Staffing Plan had an effective date of June 1, 2023, and listed the next evaluation date for January 8, 2024. CNS-B was unable to provide documentation the staffing plan was reviewed prior to after June 1, 2023. The licensee's Staffing policy dated February 25, 2022, indicated the staffing plan shall be evaluated as part of Quality Management program at least twice a year. The results of the evaluation are documented in the meeting minutes. The schedule would be posted at the beginning of the shift in a central location in each building, if applicable, accessible to staff, residents, volunteers and the public.	0 470		

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0 470	Continued From page 12 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 August 13, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.	0 480		

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0 480	Continued From page 13 TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to establish and maintain an infection control program to comply with acceptable health care, medical nursing standards for infection control after medication administration for one of one (unlicensed personnel (ULP)-C and ensuring the licensee provided adequate supplies to perform proper hand hygiene. 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	0 510		

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0 510	Continued From page 14 a large portion or all of the residents). The findings include: On August 13, 2024, at 1:31 p.m., during the facility tour with licensed assisted living director (LALD)-A, the surveyor did not observe hand soap, hand sanitizer, hand towels or paper towels in the shared bathroom on the second floor, in the bathroom located on the first floor or by the kitchen sink. The licensee's Minnesota Department of Health Food and Beverage Establishment Inspection Report dated August 13, 2024, indicated the licensee did not have soap available for hand washing at either kitchen sink or bathroom sinks. On August 14, 2024, at 2:25 p.m., LALD-A instructed ULP-C to go to the store and buy a box of gloves before ULP-C assisted R2 with insulin administration. LALD-A stated the licensee must have just ran out of gloves and sent ULP-C to the store to purchase more. At 2:38 p.m., ULP-C returned with one box of stretch vinyl exam gloves and stated he only purchased one box of gloves and was unsure how long the licensee was without gloves. At 2:39 p.m., the surveyor observed ULP-C gather R2's Novolog (rapid-acting) prefilled insulin pen insulin, dial 12 units of insulin, and inject into R2's left upper arm. ULP-C disposed of needle cap into the sharps container, removed gloves, put R2's Novolog insulin into the medication cabinet and documented the administration of R2's insulin in R2's electronic medical administration record. ULP-C did not perform hand hygiene after the removal of gloves. Immediately following R2's insulin administration, ULP-C stated he did not realize he did not perform hand hygiene after the	0 510		

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0 510	Continued From page 15 removal of gloves and should have. On August 14, 2024, at 3:30 p.m., licensed assisted living director (LALD)-A stated hand washing should be performed before and after administering resident medications and treatments. LALD-A stated the licensee replenished hand soap for staff and residents to wash their hands. The licensee's Infection Control policy dated February 15, 2022, indicated hands are washed if contaminated with blood or bodily fluid, immediately after gloves are removed, between resident contacts, and when indicted to prevent the transfer of microorganisms between resident or the environment. Gloves were work when touching blood, body fluids, secretions, excretions, non-intact skin, mucus membranes, or contaminated items. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 650 SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency	0 650		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 650	Continued From page 16 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 two employees (unlicensed personnel (ULP)-E). 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-E was hired June 16, 2023, to provide direct care services to residents of the assisted living facility. On August 15, 2024, at 8:06 a.m., the surveyor observed ULP-E administering R3's scheduled morning medications.	0 650		

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	34608	A. BUILDING: _____ B. WING _____	08/19/2024

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0 650	Continued From page 17 On August 15, 2024, at 8:13 a.m., the surveyor observed ULP-E gather R2's Novolog prefilled insulin pen, dial 12 units of insulin, and inject into R2's right upper arm. ULP-E did not prime the Novolog insulin pen two units before dialing the prescribed dose and administering R2's insulin. ULP-E's employee record lacked evidence ULP-E received the following training and demonstrated competencies as required: -documentation of requirements for all services; -reports of changes in the client's condition to the supervisor designated by the facility; -maintenance of a clean and safe environment -appropriate and safe techniques in personal hygiene and grooming, including: -hair care and bathing; -care of teeth and gums, and oral prosthetic devices; -care and use of hearing aids; and -dressing and assisting with toileting; -training on the prevention of falls for providers working with the elderly or individuals at risk of falls; -standby assistance techniques and how to perform them; -medication, exercise, and treatment reminders; -basic nutrition, meal preparation, food safety, and assistance with eating; -preparation of modified diets as ordered by a licensed health professional; -communication skills that include preserving the dignity of the client and showing respect for the client and the client's preferences, cultural background, and family; -awareness of confidentiality and privacy; -understanding appropriate boundaries between staff and clients and the client's family; -procedures to utilize in handling various	0 650		

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0 650	Continued From page 18 emergency situations; -awareness of commonly used health technology equipment and assistive device; -observing, reporting, and documenting resident status; -basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; -reading and recording temperature, pulse, and respirations of the resident; -recognizing physical, emotional, cognitive, and developmental needs of the client; -safe transfer techniques and ambulation; -range of motioning and positioning; -administering medications or treatments as required; and -other RN/professionally delegated tasks (i.e., monitor vital signs, catheter or stoma care, Broda chair, mechanical lifts). On August 15, 2024, at 12:40 p.m., licensed assisted living director (LALD)-A stated she was unable to find documentation in ULP-E employee record required training and competency evaluations noted above. LALD-A stated in the past, staff training was completed on Educare (electronic training program) but the licensee reverted back to paper. On August 15, 2024, at 10:57 a.m., ULP-E stated she was trained by the previous nurse upon hire on medication administration and her training was all recorded on paper, including the topics listed above. The licensee's Personnel Records policy dated February 15, 2022, indicted a record of each paid employee, regularly scheduled volunteer providing assisted living services, and each	0 650		

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0 650	Continued From page 19 individual contractor providing assisted living services for the licenses would be maintained and include a minimum documentation of orientation and competency evaluations. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included an up-to-date completion of a facility risk assessment.	0 660		

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0 660	Continued From page 20 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On August 14, 2024, at 11:18 a.m., the surveyor reviewed the licensee's Facility TB Risk Assessment Worksheet for Health Care Settings Licensed by Minnesota Department of Health (MDH) dated February 24, 2020. Clinical nurse supervisor (CNS)-B provided an additional Facility TB Risk Assessment; however, lacked the date the TB facility risk assessment was completed and lacked a signature of the person who completed the form. CNS-B stated she was unable to find a more current facility TB risk assessment. The licensee's Tuberculosis Screening/Prevention policy dated August 1, 2021, indicated the director was responsible for conducting the formal TB Risk Assessment and updating annually. The Minnesota Department of Health (MDH) guidelines Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July 2013, and based on CDC guidelines, indicated a TB risk assessment should be completed initially and then for low-risk settings the risk assessment should be updated every other year. No further information was provided.	0 660		

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0 660	Continued From page 21 TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and post a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect	0 680		

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0 680	Continued From page 22 all residents, staff, and visitors of the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on August 13, 2024, at 11:41 a.m., licensed assisted living director (LALD)-A stated she was responsible for developing and maintaining the licensee's EPP. LALD-A stated the EPP was in a binder locked in the medication storage cabinet. LALD-A confirmed the licensee's EPP was not prominently posted in the facility and residents or visitors did not have access unless the staff unlocked the cabinet. The licensee's EPP dated February 15, 2022, provided to the surveyor included generic instructions for staff to follow in case of a fire, severe weather, and an evacuation. The licensee's EPP lacked the following: - documentation of annual review of EPP; - a quarterly review of missing resident policy; - a facility's Hazard Vulnerability Analysis (HVA) include man-made disasters, facility based (power, water etc.), infectious diseases and pandemics; - a description of the population served by the licensee; - development of policies/procedures to address: - procedure for tracking staff and residents; - subsistence needs for staff and residents	0 680		

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0 680	Continued From page 23 during an emergency to include (food, water, medical supplies, pharmacy supplies, sewer and waste disposal, emergency lighting, fire detection, extinguishing and alarm systems; - evacuation plan which included staff responsibilities during an evacuation and transporting services for residents being evacuated; and - a communication plan that included: - arrangements with other facilities/providers to receive residents; - names and contact information for staff, entities providing services under arrangement, resident physicians, other facilities, volunteers; - contact information for federal, state, tribal, local EP staff, ombudsman, state licensing and certification agencies; - primary and alternative means for communicating with facility staff, federal, state, regional and local emergency management agencies; - a means to provide information regarding the facility's needs, and its ability to provide assistance to include information about their occupancy; and - an EP training and testing program On August 13, 2024, at 2:36 p.m., the surveyor reviewed the licensee's EPP with LALD-A. LALD-A stated the licensee's EPP was locked in the medication storage cabinet and was not available to residents, visitors or staff who do not have a key. On August 15, at 4:25 p.m., the surveyor reviewed the licensee's EPP with LALD-A, and LALD-A stated she was not aware the missing resident policy was required to be reviewed quarterly and the licensee's EPP needed more work.	0 680		

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0 680	Continued From page 24 The licensee's Emergency Preparedness policy dated August 1, 2021, indicated the licensee would have an identified plan in place to assure the safety and well-being of residents and staff during periods of an emergency disaster that disrupts services. The emergency preparedness plan/program would be reviewed/updated annually. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 690 SS=D	144G.43 Subdivision 1 Resident record (a) Assisted living facilities must maintain records for each resident for whom it is providing services. Entries in the resident records must be current, legible, permanently recorded, dated, and authenticated with the name and title of the person making the entry. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain resident records with current, legible, permanently recorded, dated, and authenticated with the name and title of the person making the entry for one of one resident (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a	0 690		

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0 690	Continued From page 25 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: R3's diagnoses included bipolar, anxiety, hallucinations, agitation, paranoia, aggressiveness, and post-traumatic stress disorder (PTSD). R3's Service Plan dated March 24, 2024, indicated R3 received medication administration, behavioral management, laundry, and housekeeping; however, lacked authentication of the date and title of the person who completed R3's service plan. In addition, R3's Nursing Assessment lacked authentication of the date and title of the person who completed R3's assessment. On August 14, 2024, at 10:23 a.m., clinical nurse supervisor (CNS)-B reviewed R3's service plan and nursing assessment and stated she was unsure why either documents were not signed and confirmed R3's service plan and nursing assessment were not signed by the person who completed the documents. The licensee's Clinical Records dated February 15, 2022, indicated a current clinical record shall be maintained for all residents. All entries into the clinical record would be legible, permanently recorded in ink, dated and authenticated with the name and title of the person making the entry. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 690		

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0 720 SS=D	144G.43 Subd. 2 Access to records The facility must ensure that the appropriate records are readily available to employees and contractors authorized to access the records. Resident records must be maintained in a manner that allows for timely access, printing, or transmission of the records. The records must be made readily available to the commissioner upon request. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure that the appropriate records for two of two residents (R2, R3), were readily available for timely access to employees, vendors, and the commissioner authorized to access the records. 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: During entrance conference on August 13, 2024, at 11:41 a.m., licensed assisted living director (LALD)-A stated resident records were mostly in paper form and the medication administration records (MAR) were electronic. LALD-A stated employees records were paper form and both employee and resident records were stored onsite in a secured office.	0 720		

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0 720	Continued From page 27 On August 13, 2024, at 3:05 p.m., the surveyor requested R2's medical records for review. At 3:09 p.m., LALD-A stated she had to leave for a family emergency and would return the next day. At 3:13 p.m., the surveyor requested R2's medical record from unlicensed personnel (ULP)-E. ULP-E stated LALD-A had left for the day and the residents records were locked in the office and she did not have key to the office. At 3:21 p.m., ULP-C stated resident charts were in the office and LALD-A had to leave for day and the office was locked and he did not have a key. ULP-C stated LALD-A must have taken the keys with her and the keys ULP-C had did not access the office. ULP-C stated residents medication administration records (MAR) were electronic but all other resident information was in paper form was in the office and did not have access to the records including the residents plan of care. On August 14, 2024, at 8:10 a.m., the surveyor informed LALD-A staff were unable to access resident records or provide resident records to the surveyor upon request on August 13, 2024, after LALD-A had left for the day. LALD-A stated she was unaware staff could not have keys to the office to access resident records and could have called her if needed and would make sure extra an key was available. The licensee's Clinical Records policy dated February 15, 2022, indicated clinical records would be maintained in such a manner that allowed for a timely access, printing, or transmission of the records. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 720		

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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: Based on observation and interview, the licensee failed to provide interconnected smoke alarms throughout the facility. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a	0 780		

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0 780	Continued From page 29 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). Findings include: On a facility tour on August 13, 2024, from 1:30 p.m. to 2:45 p.m., with licensed assisted living director (LALD)-A, it was observed that smoke alarms were not interconnected so activation of one alarm activates all alarms throughout the facility. During the tour LALD-A, tested the alarms and none of the alarms were interconnected so activation of one alarm activates all alarms throughout the facility. All dwelling units required to have multiple smoke alarms are required to have interconnected alarms so activation of one alarm activates all alarms within the dwelling unit. During the tour the smoke alarms were tested and LALD-A, verified the smoke alarms were not interconnected so activation of one alarm activates all alarms throughout the facility. TIME PERIOD FOR CORRECTION: Two (2) day.	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.	0 800		

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0 800	Continued From page 30 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a 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 a facility tour on August 13, 2024, from 1:30 p.m. to 2:45 p.m., with licensed assisted living director (LALD)-A, the surveyor made the following observations of facility hazard or disrepair: There were cigarette butts on the floor in the garage. An appropriate cigarette butt dispenser was provided outside the garage door in the designated smoking area. There was an exit sign on the door of the garage leading occupants from the assisted living through the garage as an exit route. Occupants shall not be directed through the garage as an exit as it is a higher hazard area then the assisted living in accordance with current Minnesota Fire	0 800		

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	34608	A. BUILDING: _____ B. WING _____	08/19/2024

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0 800	Continued From page 31 Code. There was a blanket screwed and nailed to the trim around the emergency escape and rescue window preventing access to the window. Emergency escape and rescue openings are required to be readily openable without the use of tools or special knowledge in accordance with current Minnesota Fire Code. The light switch was broken at the top of the second-floor stairway controlling the upstairs hallway light. The vinyl sheet flooring was loose laid over the top of the carpet floor covering below creating a trip hazard in resident sleeping room 1 upstairs and 4 in the lower level. The vinyl sheet floor is required to be installed according to manufactures installation instructions directly to the solid surface of the floor. There were no room numbers matching the evacuation plan provided on or adjacent to the resident room doors in order to identify the room for direction to an exit in the event of a fire or similar emergency. The electrical light fixture cover was missing on the ceiling in resident sleeping room 2, and above the clothes washer and dryer in the lower level. Electrical light fixture covers are required to be maintained installed according to manufactures installation instructions and current Minnesota Fire Code. The ceiling finish material was coming off the ceiling from moisture in the bathroom of resident sleeping room 4.	0 800		

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0 800	Continued From page 32 During a facility tour on August 13, 2024, at 2:45 p.m., LALD-A, verified the above listed observations while accompanying on the tour. 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 evacuation drill every other month. Evacuation of	0 810		

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0 810	Continued From page 33 the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop the fire safety and evacuation plan with required content, make the plan readily available, provide required training and drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During observation on August 13, 2024, at 2:45 p.m., the surveyor observed the fire safety and evacuation plan was not located in a central location for all staff and occupants accessibility. The plan was located in a locked file cabinet near the balcony door. The FSEP is required to be kept available for all building occupants. On August 13, 2024, at 2:45 p.m., licensed assisted living director (LALD)-A, provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN	0 810		

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0 810	Continued From page 34 The licensee provided FSEP dated February 15, 2022, failed to include the following: The location number of resident sleeping rooms were not provided on the evacuation floor plan and the plan was not posted in a conspicuous location for use by occupants to navigate to an exit in the event of a fire or similar emergency. The available FSEP did not identify specific fire protection actions for residents as evident by not providing procedures for residents to take in the event of a fire or similar emergency in writing in the plan. The available 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 resident evacuation status and unique needs for each individual resident for evacuation in writing. During an interview on August 13, 2024, at 2:50 p.m., LALD-A, stated the above listed documentation was not available. TRAINING Record review of the available documentation indicated the licensee failed to provide training to employees on the FSEP upon hire and/or at least twice per year as evident by not providing documentation the required employee training was completed. Record review of the available documentation indicated the licensee failed to provide evacuation	0 810		

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0 810	Continued From page 35 training to residents at least once per year as evident by not providing documentation training was provided based on the resident procedures required in the event of a fire or similar emergency. During an interview on August 13, 2024, at 3:00 p.m., LALD-A, stated documentation was not available for employee and resident training based on the FSEP. DRILLS Record review of the available documentation indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month as evident by providing documentation evacuation drills were completed January 6, 2024, and June 6, 2024, only. During an interview on August 13, 2024, at 3:10 p.m., LALD-A, stated the only evacuation drill documentation available was for January 6, 2024, and June 6, 2024. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
0 970 SS=C	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	0 970		

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0 970	Continued From page 36 required by law. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the assisted living contract did not include language waiving the facility's liability for health, safety, or personal property of a resident for two of two residents (R2, 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 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's diagnoses included schizophrenia and diabetes. On August 14, 2024, at 2:39 p.m., the surveyor observed unlicensed personnel (ULP)-C monitor R2's blood sugar with the Libre monitor and administer R2 12 units of Novolog (rapid-acting) insulin. R2's Service Plan dated July 22, 2022, indicated R2 received medication administration, behavioral management, laundry, and housekeeping. R3 R3's diagnoses included bipolar, anxiety, hallucinations, agitation, paranoia,	0 970		

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0 970	Continued From page 37 aggressiveness, and post traumatic stress disorder (PTSD). On August 15, 2024, at 8:06 a.m., the surveyor observed ULP-E administering R3's scheduled morning medications. R3's Service Plan dated March 24, 2024, indicated R3 received medication administration, behavioral management, laundry, and housekeeping. R2 and R3's Assisted Living Contract signed July 22, 2022, included the following waiver of liability language: -under Insurance Liability and Release section- indicted the resident agrees the licensee would not be liable to the resident for any personal injury or property damage (including, without limitation, damage to, or loss or theft of, automobiles or personal property of resident, suffered by the resident or the resident's agents, guests or invitees, unless and to the extent that that the injury or damage is cause by the negligence of the licensee or its employees or agents. The resident releases the licensee from liability for any personal injury or property damage suffered the resident or the resident's agent, guest, or invitee, unless caused by the negligence of the licensee or its employees or agents; and -under Indemnification, indicated the licensee shall not be liable for any damage or injury to the resident, or any other person, or property, occurring on the premises, or any part thereof, or in common areas thereof, and the resident aggress to hold the licensee harmless from any claims or damages unless caused solely by negligence of the licensee. On August 13, 2024, at 2:20 p.m., licensed	0 970		

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0 970	Continued From page 38 assisted living director (LALD)-A stated the licensee's assisted living contract was the same contract used for all residents. LALD-A confirmed the waiver of liability language in the assisted living contract and was unaware of the requirement. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 970		
01290 SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure all employees with access to residents and resident records had a cleared background study completed via Minnesota Department of Human Services (DHS)NetStudy 2.0, for one of six employees	01290		

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01290	Continued From page 39 (unlicensed personnel (ULP)-D). This had the potential to affect all residents, employees, and visitors. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). This resulted in an immediate correction order on August 14, 2024. The findings include: ULP-D was hired on January 13, 2022, to provide direct care services to residents of the facility. ULP-D's employee record lacked documentation of a cleared background study. Review of NetStudy 2.0 on August 14, 2024, at 10:26 a.m., indicated a background study for ULP-D was submitted under a COVID-19 waiver, which expired December 31, 2022. A complete background study had not been submitted for ULP-D after the waivered study expired. On August 14, 2024, at 10:30 a.m., licensed assisted living director (LALD)-A stated ULP-D was employed by the licensee and worked full-time on the night shift (11:00 p.m., to 7:00 a.m.,). LALD-A stated ULP-D provided independent direct resident cares during their shift, worked alone and was not under direct supervision by another employee. LALD-A stated	01290		

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01290	Continued From page 40 there was no background study clearance letter in ULP-D's employee record. The licensee's Recruitment and Hiring policy dated February 15, 2022, indicated in accordance with applicable state and federal regulations, the licensee would assure all persons were appropriately screened prior to employment. Criminal Background Checks would be submitted to Minnesota DHS following the step-by-step procedures established by DHS. The director or designee would be responsible for initiating the criminal background study for new employees. NetStudy 2.0 (or current version) would be used for the background check. The employee would be directed to locations established by DHS to obtain fingerprint scans and the background study would be maintained in the employee's personnel file. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE	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:	01370		

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01370	Continued From page 41 (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; (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 included all the required training for one of two employees (unlicensed personnel (ULP)-C). 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	01370		

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01370	Continued From page 42 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-C was re-hired on January 3, 2023, to provide direct care services to residents of the facility. On August 14, 2024, at 2:39 p.m., the surveyor observed ULP-C administering R2's Novolog (rapid-acting) insulin. ULP-C's s employee record included Comprehensive Home Care Orientation Training and Competencies completed from ULP-C's previous employment dated December 6, 2019; however, ULP-C's record did not include evidence ULP-C received the following required training and/or competencies after ULP-C left employment for a few years and was rehired under the licensee's assisted living license in 2023 to include: -documentation of requirements for all services; -reports of changes in the client's condition to the supervisor designated by the facility; -maintenance of a clean and safe environment -appropriate and safe techniques in personal hygiene and grooming, including: -hair care and bathing; -care of teeth and gums, and oral prosthetic devices; -care and use of hearing aids; and -dressing and assisting with toileting; -training on the prevention of falls for providers working with the elderly or individuals at risk of falls; -standby assistance techniques and how to	01370		

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01370	Continued From page 43 perform them; -medication, exercise, and treatment reminders; -basic nutrition, meal preparation, food safety, and assistance with eating; -preparation of modified diets as ordered by a licensed health professional; -communication skills that include preserving the dignity of the client and showing respect for the client and the client's preferences, cultural background, and family; -awareness of confidentiality and privacy; -understanding appropriate boundaries between staff and clients and the client's family; -procedures to utilize in handling various emergency situations; and -awareness of commonly used health technology equipment and assistive devices. On August 15, 2024, at 8:41 a.m., licensed assisted living director (LALD)-A stated ULP-C was previously hired in 2019, and stopped working for the provider for a few years and was rehired under the providers assisted living licensee on July 3, 2023. LALD-A stated she was unable to find documentation in ULP-C's employee record indicating ULP-C had received the required training and demonstrated competencies noted in the areas above when ULP-C was rehired by the licensee. The licensee's Staff Competency policy dated February 15, 2022, indicated all residents would receive quality service delivered by staff who were educated and competent in the delivery assisted living services. The licensee was committed to meeting or exceeding current practice standards. Training and competency evaluations for all unlicensed personnel include the following. Unlicensed personnel may not work for the licensee until they have successfully	01370		

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01370	Continued From page 44 passed the written (at 80%) and demonstration competency evaluation in the following areas: -documentation requirements for all services provided; -reports of changes in the resident's condition to the supervisor designated by the assisted living provider; -basic infection control, including blood-borne pathogens; -maintenance of a clean and safe environment; -appropriate and safe techniques in personal hygiene and grooming, including hair care and bathing; care of teeth, gums and oral prosthetic devices; care and use of hearing aids; and dressing and assisting with toileting. -training on the prevention of falls for providers working with the elderly or those at risk of falls; -standby assistance techniques and how to perform them; -medication, exercise and treatment reminders; -basic nutrition, meal preparation and preparation of modified diets as ordered by a licensed health professional, food safety and assistance with eating; -communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background and family; -awareness of confidentiality and privacy; -understanding appropriate boundaries between staff, residents and the resident's family; and -procedures to utilize in handling various emergency situations Awareness of commonly used health technology equipment and assistive devices. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		

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	34608	A. BUILDING: _____ B. WING _____	08/19/2024

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01380 SS=D	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and competency evaluations included all the required training for one of two employees (unlicensed personnel (ULP)-C). 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:	01380		

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01380	Continued From page 46 ULP-C was re-hired on January 3, 2023, to provide direct care services to residents of the facility. On August 14, 2024, at 2:39 p.m., the surveyor observed ULP-C monitor R2's blood glucose (sugar) with the FreeStyle Libre monitor (measures blood glucose through a sensor) and administer R2's Novolog (rapid-acting) insulin. ULP-C's s employee record included Comprehensive Home Care Orientation Training and Competencies completed from ULP-C's previous employment dated December 6, 2019; however, ULP-C's record did not include evidence ULP-C was retrained and received the following required training and/or competencies after ULP-C left employment for a few years and was rehired under the licensee assisted living license in 2023 to include: -observing, reporting, and documenting resident status; -basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; -reading and recording temperature, pulse, and respirations of the resident; -recognizing physical, emotional, cognitive, and developmental needs of the client; -safe transfer techniques and ambulation; -range of motioning and positioning; -administering medications or treatments as required; and -other RN/professionally delegated tasks (i.e., monitor vital signs, catheter or stoma care, Broda chair, mechanical lifts). On August 15, 2024, at 8:41 a.m., licensed	01380		

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01380	Continued From page 47 assisted living director (LALD)-A stated ULP-C was previously hired in 2019, and stopped working for the provider for a few years and was rehired under the providers assisted living licensee on July 3, 2023. LALD-A stated she was unable to find documentation in ULP-C's employee record indicating ULP-C received the required training and demonstrated competencies in the topics noted above when ULP-C was rehired by the licensee. The licensee's Staff Competency policy dated February 15, 2022, indicated all residents would receive quality service delivered by staff who were educated and competent in the delivery assisted living services. The licensee was committed to meeting or exceeding current practice standards. Training and competency evaluations for all unlicensed personnel include the following. Unlicensed personnel may not work for the licensee until they have successfully passed the written (at 80%) and demonstration competency evaluation in the following areas: -documentation requirements for all services provided; -reports of changes in the resident's condition to the supervisor designated by the assisted living provider; -basic infection control, including blood-borne pathogens; -maintenance of a clean and safe environment; -appropriate and safe techniques in personal hygiene and grooming, including hair care and bathing; care of teeth, gums and oral prosthetic devices; care and use of hearing aids; and dressing and assisting with toileting. -training on the prevention of falls for providers working with the elderly or those at risk of falls; -standby assistance techniques and how to perform them;	01380		

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01380	Continued From page 48 -medication, exercise and treatment reminders; -basic nutrition, meal preparation and preparation of modified diets as ordered by a licensed health professional, food safety and assistance with eating; -communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background and family; -awareness of confidentiality and privacy; -understanding appropriate boundaries between staff, residents and the resident's family; and -procedures to utilize in handling various emergency situations Awareness of commonly used health technology equipment and assistive devices. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380		
01460 SS=F	144G.63 Subdivision 1 Orientation of staff and supervisors All staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. The orientation may be incorporated into the training required under subdivision 5. The orientation need only be completed once for each staff person and is not transferable to another facility. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure staff	01460		

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01460	Continued From page 49 providing and supervising direct services completed orientation to assisted living facility licensing requirements and regulations before providing services for one of two employees (clinical nurse supervisor (CNS)-B). This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on August 13, 2024, at 11:41 a.m., licensed assisted living director (LALD)-A stated the licensee was aware of required contents for an employee record. CNS-B had a hire date of May 31, 2024, to supervise and provide assisted living services to the licensee's residents. On August 14, 2024, during the course of the survey, the surveyor observed CNS-B provide care and services to the licensee's residents. CNS-B's employee record lacked orientation to assisted living requirements at the time of hire to include: -an overview of chapter 144G.08 through 144G.93; -an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person;	01460		

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01460	Continued From page 50 -handling of emergencies and use of emergency services; -compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); -the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; -the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; -handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; -consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and -a review of the types of assisted living services the employee will be providing and the facility's category of licensure. On August 15, 2024, at 7:59 a.m., LALD-A stated CNS-B had not completed any training including the required orientation to assisted living licensing and requirements. LALD-A was unable to provide a reason why CNS-B had not completed the required orientation to assisted living training. The licensee's Personnel Records policy dated February 15, 2022, indicated a personnel record would be developed for each staff member upon hire and include documentation of orientation. No further information was provided.	01460		

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01460	Continued From page 51 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01460		
01470 SS=E	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff 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.	01470		

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01470	Continued From page 52 (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure staff providing services completed an orientation to assisted living facility licensing requirements and regulations before providing services for two of two employees (unlicensed personnel (ULP)-C, ULP-E). 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	01470		

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01470	Continued From page 53 situation has occurred repeatedly; but is not found to be pervasive). The findings included: ULP-C ULP-C was hired on January 3, 2023, to provide direct care services to residents of the facility. On August 14, 2024, at 2:39 p.m., the surveyor observed ULP-C administering R2's Novolog (rapid-acting) insulin. ULP-E ULP-E was hired June 16, 2023, to provide direct care services to residents of the facility. On August 15, 2024, at 8:06 a.m., the surveyor observed unlicensed personnel ULP-E administering R2's Novolog insulin. ULP-C and ULP-E's employee record indicated ULP-C and ULP-E completed orientation to home care training; however, ULP-C and ULP-E's records lacked evidence of completing the following assisted living orientation 144G requirement topics before providing assisted living services to the licensee's residents: -an overview of the 144G statutes; -assisted living Bill of Rights; -review of types of Assisted Living services the employee will provide and provider's scope of license; -principles of person-centered planning/service delivery; and -hearing loss (optional). On August 15, 2024, at 8:41 a.m., licensed assisted living director (LALD)-A stated ULP-C was previously hired in 2019, and stopped	01470		

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01470	Continued From page 54 working for the provider for a few years and was rehired under the providers assisted living licensee on July 3, 2023. LALD-A stated she was unable to find documentation in ULP-C's employee record indicating ULP-C had received the required assisted living training noted above when ULP-C was rehired by the licensee. At 10:45 a.m., LALD-A stated ULP-E's Staff Orientation Outline and Sign-Off sheet did not indicate ULP-E completed the required orientation to assisted living content noted above. The licensee's Personnel Records policy dated February 15, 2022, indicated a personnel record would be developed for each staff member upon hire and include documentation of orientation. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01470		
01490 SS=F	144G.63 Subd. 4 Training required relating to dementia All direct care staff and supervisors providing direct services must demonstrate an understanding of the training specified in section 144G.64. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the required amount of dementia care training was completed in the required time frame in accordance with 144G.64 for three of three employees (clinical nurse supervisor (CNS)-B, unlicensed personnel (ULP)-C, ULP-E).	01490		

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01490	Continued From page 55 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: CNS-B CNS-B was hired May 31, 2024, to provide supervision and direct care services for the licensee's residents. On August 14, 2024, during the course of the survey, the surveyor observed CNS-B provide care and services to the licensee's residents. ULP-C ULP-C was hired on January 3, 2023, to provide direct care services to residents of the facility. On August 14, 2024, at 2:39 p.m., the surveyor observed ULP-C administering R2's Novolog (rapid-acting) insulin. ULP-E ULP-E was hired June 16, 2023, to provide direct care services to residents of the facility. On August 15, 2024, at 8:06 a.m., the surveyor observed unlicensed personnel ULP-E administering R2's Novolog insulin. CNS-B, ULP-C, ULP-E's records lacked documentation they completed at least eight	01490		

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01490	Continued From page 56 hours of initial dementia care training on required topics within 120 working hours, including: -an explanation of Alzheimer's disease and other dementia; -assistance with activities of daily living; -problem solving with challenging behaviors; -communication skills; and -person-centered planning and service delivery. On August 15, 2024, at 7:59 a.m., LALD-A stated CNS-B had not completed any training courses including the required dementia care training noted above. At 8:41 a.m., LALD-A stated ULP-C was previously hired in 2019, and stopped working for the provider for a few years and was rehired under the providers assisted living licensee on July 3, 2023. LALD-A stated she was unable to find documentation in ULP-C's employee record indicating ULP-C had completed the required dementia training when ULP-C was rehired by the licensee. At 10:45 a.m., LALD-A stated she was unable to find documentation in ULP-E's employee record ULP-E completed the required dementia training noted above. The licensee's Personnel Records policy dated February 15, 2022, indicated a personnel record would be developed for each staff member upon hire and include documentation of orientation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01490		
01530 SS=F	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the	01530		

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01530	Continued From page 57 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; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure three of three employees (clinical nurse supervisor (CNS)-B, unlicensed personnel (ULP)-C, ULP-E) received the required amount of dementia care training in the required time frame. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and	01530		

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01530	Continued From page 58 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: CNS-B CNS-B was hired May 31, 2024, to provide supervision and direct care services for the licensee's residents. On August 14, 2024, during the course of the survey, the surveyor observed CNS-B provide care and services to the licensee's residents. ULP-C ULP-C was hired on January 3, 2023, to provide direct care services to residents of the facility. On August 14, 2024, at 2:39 p.m., the surveyor observed ULP-C administering R2's Novolog (rapid-acting) insulin. ULP-E ULP-E was hired June 16, 2023, to provide direct care services to residents of the facility. On August 15, 2024, at 8:06 a.m., the surveyor observed unlicensed personnel ULP-E administering R2's Novolog insulin. CNS-B's record lacked documentation CNS-B completed at least eight hours of initial dementia care training on required topics within 120 hours of start date; furthermore, ULP-C and ULP-E's records lacked documentation ULP-C and ULP-E completed at least eight hours of initial dementia care training within 160 hours of start date.	01530		

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	34608	A. BUILDING: _____ B. WING _____	08/19/2024

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01530	Continued From page 59 On August 15, 2024, at 7:59 a.m., LALD-A stated CNS-B had not completed any training courses including eight hours of initial dementia care training within 120 hours of start date. At 8:41 a.m., LALD-A stated ULP-C was previously hired in 2019 and stopped working for the provider for a few years and was rehired under the providers assisted living licensee on July 3, 2023. LALD-A stated she was unable to find documentation in ULP-C's employee record indicating ULP-C completed eight hours of initial dementia training when ULP-C was rehired by the licensee. At 10:45 a.m., LALD-A stated she was unable to find documentation in ULP-E's employee record ULP-E completed the required eight hours initial dementia training noted within 160 hours of start date. The licensee's Personnel Records policy dated February 15, 2022, indicated a personnel record would be developed for each staff member upon hire and include documentation of orientation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01530		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on	01640		

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01640	Continued From page 60 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 was revised to reflect the current services provided for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2's diagnoses included schizophrenia and diabetes. On August 14, 2024, at 2:39 p.m., the surveyor observed unlicensed personnel (ULP)-C monitor R2's blood sugar with the Libre monitor	01640		

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01640	Continued From page 61 (measures glucose through a sensor) and administer R2 12 units of Novolog (rapid-acting) insulin. R2's August 2024 Medication Administration Report (MAR), indicated R2 received blood glucose monitoring three times a day. R2's Service Plan dated July 22, 2022, did not include R2 received blood glucose monitoring three times a day. On August 14, 2024, at 1:02 p.m., clinical nurse supervisor (CNS)-B verified R2 received blood glucose monitoring three times a day and R2's service plan did not include blood glucose monitoring services. The licensee's Service Plan policy, date February 15, 2022, indicated the service plan would include a description of services to be provided, the frequency of each service, fees for service, and identification of the staff or categories of staff who would provide the services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01640		
01750 SS=I	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated	01750		

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01750	Continued From page 62 the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the registered nurse (RN) instructed unlicensed personnel (ULP)-C, ULP-D) in the proper methods to administer medications, and the unlicensed personnel had demonstrated the ability to competently follow the procedures for administering medications. This had the potential to affect all residents receiving assisted living services. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). This practice resulted in an immediate correction order on August 15, 2024. The findings include: On August 13, 2024, at 12:23 p.m., during entrance conference, licensed assisted living director (LALD)-A stated the licensee employed a new part-time RN who completed resident assessments and was responsible for training	01750		

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01750	Continued From page 63 and completing staff competency evaluations. R2's diagnoses included schizophrenia and diabetes. R2's Service Plan dated July 22, 2022, indicated R2 received medication administration by the licensee. R2's record lacked current annual physician orders for prescribed medications and treatments. R2's August 2024 Medication Administration Report (MAR) indicated R2 received Novolog Flex-pen U-100 insulin to inject 12 units under the skin three times a day with meals and to see drug leaflet, and Lantus Solostar U-100 insulin (long-acting) inject 36 units at bedtime under the skin, see drug leaflet; however, R2's (MAR) did not include directions to prime the insulin pens two units prior to dialing insulin dose and administering. ULP-C ULP-C was had a hire date of July 3, 2023, to provide direct care services to the residents of the assisted living facility. On August 14, 2024, at 2:39 p.m., the surveyor observed ULP-C gather R2's Novolog prefilled insulin pen (rapid-acting insulin), dial 12 units of insulin, and inject into R2's left upper arm. ULP-C did not prime the Novolog insulin pen two units before dialing the prescribed dose and administering R2's insulin. Immediately following the insulin administration, ULP-C stated he was not trained to dial two units of insulin prior to dialing the prescribed dose.	01750		

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01750	Continued From page 64 ULP-C's training record included documentation of Comprehensive Home Care Orientation Training and Competencies for medication administration from ULP-C's previous employment dated December 6, 2019; however, ULP-C's record did not include evidence ULP-C was re-trained and demonstrated competency to the RN for medication administration after ULP-C was re-hired on July 3, 2023. On August 15, 2024, at 8:41 a.m., LALD-A stated ULP-C was previously hired in 2019, and stopped working for the provider for a few years and was rehired under the providers assisted living licensee on July 3, 2023. LALD-A stated she was unable to find documentation in ULP-C's employee record indicating ULP-C had received training and demonstrated competencies to the RN in medication administration when ULP-C was rehired by the licensee. ULP-E ULP-E was hired June 16, 2023, to provide direct care services to residents of the assisted living facility. On August 15, 2024, at 8:06 a.m., the surveyor observed ULP-E administering R3's scheduled morning medications. On August 15, 2024, at 8:13 a.m., the surveyor observed ULP-E gather R2's Novolog prefilled insulin pen, dial 12 units of insulin, and inject into R2's right upper arm. ULP-E did not prime the Novolog insulin pen two units before dialing the prescribed dose and administering R2's insulin. ULP-E's employee record lacked evidence ULP-E completed training and demonstrated competency to the RN in medication	01750		

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01750	Continued From page 65 administration. On August 15, 2024, at 10:57 a.m., ULP-E stated she was trained by the previous nurse upon hire on medication administration and her training was all recorded on paper. On August 15, 2024, at 1:11 p.m., the surveyor requested written instructions on insulin administration and LALD-A stated she was unaware if the licensee had a written policy or procedure for administering insulin. LALD-A stated she was trained by the RN on medication administration including insulin and was unaware about priming insulin before dialing the prescribed dose. On August 15, 2024, at 1:28 p.m., ULP-C obtained the manufacture directions from R2's Novolog insulin box located in the locked medication refrigerator and reviewed with surveyor. The manufacturer's instructions for Novolog insulin flex pens dated October 2023, indicated to prime the Novolog insulin pen two units before each injection to ensure proper dose. ULP-C stated she was unaware she was supposed to prime the insulin pen two units prior to dialing the insulin dose and administering. The licensee's Delegation of Assisted Living Tasks policy dated February 15, 2022, indicated the clinician (Registered Nurse or licensed health professional) RN was responsible for appropriately delegating tasks to the staff who are competent and possess the knowledge and skills consistent with the complexity of the tasks in accordance with the appropriate Minnesota Practice Act. The clinician would instruct the home health aide in the proper methods to perform the procedure, provide written	01750		

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01750	Continued From page 66 instructions specific to the resident and the home health aide would demonstrate to the clinician competency in the procedure and document in his/her personnel file. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	01750		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were administered per the manufacturer's instructions for one of two residents (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	01760		

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01760	Continued From page 67 was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2's diagnosis included diabetes type II. R2's Service Plan dated July 22, 2022, indicated R2 received medication assistance services. R2's record included electronic prescriptions for Novolog Flex pen (rapid-acting) insulin 12 units three times a day with meals. R2's August 2024 Medication Administration Report (MAR) indicated R2 was scheduled and received Novolog Flex pen insulin 12 units three times a day. On August 14, 2024, at 2:39 p.m., the surveyor observed unlicensed personnel (ULP)-C dial up 12 units of Novolog insulin and administer into R2's left upper arm. ULP-C did not prime the Novolog insulin pen two units prior to dialing prescribed dose and administering to R2. On August 15, 2024, at 8:06 a.m., the surveyor observed ULP-E dial up 12 units of Novolog insulin and administer into R2's right upper arm. ULP-E did not prime the Novolog insulin pen two units prior to dialing prescribed dose and administering to R2. On August 15, 2024, at 8:41 a.m., ULP-E stated she was trained by the previous registered nurse to prime insulin pens two units before dialing prescribed dose.	01760		

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01760	Continued From page 68 On August 15, 2024, at 1:11 p.m., the surveyor requested written instructions on insulin administration and LALD-A stated she was unaware if the licensee had a written policy or procedure for administering insulin. LALD-A stated she was trained by the previous RN on medication administration including insulin and was unaware about priming insulin before dialing the prescribed dose. The licensee's Medication Administration policy dated February 15, 2022, indicated the registered nurse may delegate medication administration to an unlicensed staff and the registered nurse would prepare written instructions for the ULP in proper methods to administer medications with respect to each resident. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01790 SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be	01790		

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01790	Continued From page 69 labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and	01790		

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01790	Continued From page 70 (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure two of unlicensed personnel (ULP-C , ULP-E) were trained and had demonstrated competency to prepare and give medications for residents having unplanned time away. In addition, the licensee failed to ensure the registered nurse (RN) developed written procedures with all the required content for ULP providing medications for residents having unplanned time away when the licensed nurse was not available. 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: ULP-C ULP-C was hired on January 3, 2023, to provide direct care services to residents of the facility which include medication administration. On August 14, 2024, at 2:39 p.m., the surveyor observed ULP-C administering R2's Novolog (rapid-acting) insulin.	01790		

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01790	Continued From page 71 ULP-E ULP-E was hired June 16, 2023, to provide direct care services to residents of the facility which include medication administration. On August 15, 2024, at 8:31 a.m., the surveyor observed ULP-E administering R2's scheduled morning medications. ULP-C and ULP-E's employee records lacked evidence to indicate ULP-C and ULP-E had been trained and had demonstrated competency to provide medications to residents for unplanned times away from home. The licensee's Medication Management Plan for Residents Away from Home policy dated August 1, 2021, indicated for unplanned times away from home for temporary periods when an adequate medication supply cannot be obtained from the pharmacy or set up by the registered nurse in a timely manner, the registered nurse may delegate to an unlicensed personnel (home health aide) to provide the medications based on the following: -the registered nurse had trained the home health aide and determine the home health aide competency to follow the procedures for giving medications to residents; -the registered nurse has instructed the home health aide to ensure that all appropriate precautions are taken; -the registered nurse would had developed written procedures/protocols for the home health aide, including any special instructions or procedures regarding controlled substances (refer also to Protocol for residents away from home) including: -the type of container(s) to be used for the medications appropriate to the facility's	01790		

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01790	Continued From page 72 medication system; -how the container or container(s) should be labeled; -written information about the medications to provided; -documenting requirements: date the medications were provided, who received the medications, who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; -how the RN shall be notified that medications were provided and whether the RN should be notified before the medications are given to the client or the client's representative; -upon return to the facility, the home health aide must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication; and -the RN must review the setup of mediation and documentation to ensure that the issuance of medications by the home health aide and the return of any unused medications were handled appropriately. On August 15, 2024, at 10:45 am, licensed assisted living director (LALD)-A stated the licensee had a policy for planned and unplanned time away; however, was unsure if the RN had developed a written procedure for unplanned time away. LALD-A stated she was unable to find documentation in ULP-C and ULP-E's employee records to indicate ULP-C and ULP-E were trained and demonstrated competency in preparing medications for residents when away from the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	01790		

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	34608	A. BUILDING: _____ B. WING _____	08/19/2024

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01790	Continued From page 73 days	01790		
01820 SS=D	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure current written or electronically recorded prescriptions were obtained for one of two residents (R3) who received medication management services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R3's diagnoses included bipolar, anxiety, hallucinations, agitation, paranoia, aggressiveness, and post traumatic stress disorder (PTSD). R3's Service Plan dated March 24, 2024, indicated R3 received medication assistance services.	01820		

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01820	Continued From page 74 On August 15, 2024, at 8:06 a.m., the surveyor observed unlicensed personnel administering R3's scheduled morning medications. R3's August 2024 Medication Administration Report (MAR) indicted R3 was scheduled and received the following medications: -aspirin (heart health) 81 milligrams (mg) daily; -lisinopril (for high blood pressure) 10 mg daily; -metoprolol succinate (for high blood pressure) 25 mg one-half tablet daily; -rosuvastatin (for high cholesterol) 40 mg daily; and -vitamin D3 (supplement) 1,000 units daily. R3's record lacked signed prescription orders for R3's medications noted above. On August 14, 2024, at 9:38 p.m., clinical nurse supervisor (CNS)-B stated she was unsure why R3's record did not have prescriber orders for medications or how the previous nurse obtained medication orders. CNS-B stated she recently sent R3's provider a medication list for signed orders. The surveyor requested a copy of the fax CNS-B sent to R3's provider and did not receive. The licensee's Medication Orders policy dated February 15, 2022, indicted the licensee would maintain a current written or electronically recorded prescription for all prescribed medications managed for the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		

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01830	Continued From page 75	01830		
01830 SS=D	144G.71 Subd. 14 Renewal of prescriptions Prescriptions must be renewed at least every 12 months or more frequently as indicated by the assessment in subdivision 2. Prescriptions for controlled substances must comply with chapter 152. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to renew prescriptions at least every 12 months for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During entrance conference on August 13, 2024, at 11:41 a.m., licensed assisted living director (LALD)-A stated the licensee provided medication management services to the residents at the facility. R2's diagnoses included schizophrenia and diabetes type II. R2's Service Plan dated July 22, 2022, indicated R2 received medication assistance services. On August 14, 2024, at 2:39 p.m., the surveyor	01830		

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01830	Continued From page 76 observed unlicensed personnel (ULP)-C administering R2's scheduled afternoon insulin. On August 15, 2024, at 8:31 a.m., the surveyor observed ULP-E administering R2's scheduled morning medications. R2's record included electronic prescriptions for the following medications: -atorvastatin (high cholesterol) 40 mg daily dated June 15, 2023; -lisinopril (for high blood pressure) 2.5 milligrams (mg) daily dated June 15, 2023 -metformin (for diabetes) 1000 mg one tablet twice a day with meals dated June 15, 2023; -Novolog Flex pen insulin (rapid-acting) inject 12 units three times a day dated June 15, 2023; and -Lantus Solostar insulin (long-acting) inject 36 units at bedtime dated June 15, 2023. R2's August 2024 Medication Administration Record (MAR) indicated R2 was scheduled and received the following medications: -atorvastatin 80 mg one-half tablet at bedtime; -lisinopril 2.5 milligrams (mg) in the morning; -metformin 1000 mg one tablet twice a day with meals; -Novolog Flex pen insulin inject 12 units under the skin three times a day; and -Lantus Solostar insulin inject 36 units under the skin at bedtime; R2's record lacked prescriber orders renewed at least every 12 months for the medications noted above. On August 14, 2024, at 2:04 a.m., clinical nurse supervisor (CNS)-B stated R2's record did not include annual prescriber orders for medications, only electronic prescriptions and CNS-B recently	01830		

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01830	Continued From page 77 faxed R2's provider to obtain annual medication orders. The licensee's Prescriber's Orders policy dated February 15, 2022, indicated medication orders would be renewed at least every year or when changes occur. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01830		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure refrigerated medications were maintained at manufacturer recommended temperatures by failing to monitor and document medication refrigerator temperatures for one of one medication refrigerator. 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	01880		

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01880	Continued From page 78 a large portion or all of the residents). The findings include: During entrance conference on August 13, 2024, at 11:41 a.m., licensed assisted living director (LALD)-A stated the license provided secured medication storage. At 1:15 p.m., the surveyor requested three months of recorded medication refrigerator temperatures and LALD-A stated she was unsure if the temperatures were being monitored and would have to ask clinical nurse supervisor (CNS)-B. On August 13, 2024, at 3:26 p.m., the surveyor observed the medication refrigerator with unlicensed personnel (ULP)-C. ULP-C stated he was unsure who was monitoring refrigerator temperatures and verified there was no thermometer in the medication refrigerator and confirmed the following medications being stored: -six unopened boxes of R1's Lantus Solostar (long-acting) prefilled insulin pens containing five insulin pens per box and 11 single Lantus Solostar prefilled insulin pens; and -two unopened boxes of R1's Novolog Flexpen (rapid-acting) prefilled insulin pens containing five insulin pens per box and seven single Novolog Flexpen prefilled insulin pens. On August 14, 2024, at 9:28 a.m., LALD-A stated the licensee had not been monitoring medication refrigerator temperatures and was unaware of the requirement. The manufacturer's instructions for Lantus Solostar insulin pen dated June 2022, indicated to store unopened Lantus insulin in the refrigerator at 36 to 46 degrees Fahrenheit (F) and do not freeze.	01880		

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01880	Continued From page 79 The manufacturer's instructions for Novolog Flex insulin pen dated November 2021, indicated to store unopened Novolog in the refrigerator at 36 to 46 degrees F and do not freeze. The licensee's Storage/Control of Medications policy, dated August 1, 2021, indicated when medications are managed and stored by the licensee, medications would be kept securely locked and stored per manufacturer directions and only staff would have access to stored medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were maintained bearing the original prescription label with information regarding the direction for use, medication name, medication dosage, resident's name, and the pharmacy in which it had been issued for one of two residents (R2) who received medication storage by the licensee.	01890		

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01890	Continued From page 80 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2's diagnoses included schizophrenia and diabetes. R2's Service Plan dated July 22, 2022, indicated R2 received medication administration by the licensee. R2's record included electronic prescriptions dated June 15, 2023, to include Novolog Flex-pen (rapid-acting) insulin 12 units three times a day and Lantus Solostar (long-acting) insulin 36 units at bedtime. R2's record lacked current annual physician orders for prescribed medications and treatments. R2's August 2024 Medication Administration Report (MAR) indicated R2 received Novolog Flex-pen U-100 insulin to inject 12 units under the skin three times a day with meals, and Lantus Solostar U-100 insulin inject 36 units at bedtime under the skin. On August 14, 2024, at 2:39 p.m., the surveyor observed unlicensed personnel (ULP)-C gather R2's Novolog prefilled insulin pen insulin, dial 12	01890		

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01890	Continued From page 81 units of insulin, and inject into R2's left upper arm. R2's Novolog insulin lacked an original prescription label with information regarding the direction for use, medication name, medication dosage, resident's name, and the pharmacy in which it had been issued. Immediately following R2's insulin administration, ULP-C verified R2's insulin pens did not have individual prescription labels on each insulin pen and stated the prescription label was only on the box of insulin located in the medication refrigerator. On August 14, 2024, at 3:28 p.m., licensed assisted living director (LALD)-A verified R2's Novolog and Lantus insulin pens did not have prescription labels of each individual insulin pens and would need to contact the pharmacy. The licensee's Storage/Control of Medications policy dated August 1, 2021, indicated stored medications should be clearly labeled with the following content: -prescription number and name of medication; -strength and quality; -expiration date for time-dated drugs; -directions for use; -resident's name; -prescriber's name; -date issued; and -name and address of licensed pharmacy issuing the medication. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01910 SS=F	144G.71 Subd. 22 Disposition of medications	01910		

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01910	Continued From page 82 (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document in the resident record the disposition of the medications as required for one of one resident (R1) upon discharge. 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:	01910		

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01910	Continued From page 83 R1's diagnoses included schizophrenia, bipolar and post-traumatic stress disorder (PTSD). R1's Service Plan dated April 4, 2024, indicated R1's services included medication management, behavioral management, laundry, housekeeping, and meals. R1's undated Individualized Medication Management Plan indicated R1 received medication administration by facility staff, the facility nurse was responsible for monitoring medication supplies and refills, and R1's medications were stored in a locked medication cart. R1's Medication Administration Report (MAR) dated May 1, 2024 through May 29, 2024, indicated R1 was scheduled and received the following medications: -atorvastatin 10 milligrams (mg) (used for high cholesterol) daily; -benzotropine 0.5 mg (depressant) one tablet twice a day; -fluoxetine 40 mg (antidepressant) two capsules daily; -prazosin 1 mg (used to treat high blood pressure, PTSD) at bedtime; and -risperidone 4 mg (used to treat schizophrenia) one tablet twice a day; R1's Discharge Summary dated May 24, 2024, indicated R1 was admitted April 6, 2024, and discharged May 24, 2024. R1 received assistance with medication management, scheduling appointments, social activities, and meals. R1's Discharge Summary boxes were blank to indicate whether R1 received his belonging and/or medications.	01910		

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01910	Continued From page 84 R1's record lacked documentation for the disposition of the medications noted above to include the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. On August 14, 2024, at 10:23 a.m., clinical nurse supervisor (CNS)-B provided a blank Medication Disposition Form and stated that was the form the licensee used when documenting the disposition of resident medications. CNS-B verified the Medication Disposition Form did not include an area to document the medication prescription number, and would be missing for all discharged residents. On August 15, 2024, at 2:30 p.m., licensed assisted living director (LALD)-A stated R1 left the facility on his own and went to a detox center and never retruned to the facility. LALD-A stated the licensee did not document the disposition of R1's medications because R1 did not have any medications at the time R1 left the facility. LALD-A verified R1's May 2024 MAR indicated R1 received medications on May 24, 2024, the day R1 left the facility. LALD-A stated she did not document in R1's records any information regarding the status of R1's medications at the time of R1's discharge. The licensee's Disposition and Disposal of Medications policy dated February 15, 2022, indicated unused portions of current medications being managed by the facility would be given to the resident or responsible party when the resident's service plan ends, medication management services are no longer provided under the service plan or upon discharge; and a	01910		

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01910	Continued From page 85 note regarding this is placed in the clinical record. The licensee would document the following information in the clinical record: -name, strength and prescription number of medication, as applicable; -quantity; -method of disposition or to whom the medications were given; -name(s)/signature(s) of staff or other individuals involved in disposition; and -if applicable, to whom the medications were given. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
01950 SS=D	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions	01950		

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BRIGHT LIVING LLC	7309 ZANE AVENUE NORTH BROOKLYN PARK, MN 55443

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01950	Continued From page 86 in the resident's record; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure instructions, specified in writing for each resident, and documented those instructions in the resident's record for one of one resident (R2) who received blood glucose monitoring. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2's diagnoses included schizophrenia and diabetes. On August 14, 2024, at 2:39 p.m., the surveyor observed unlicensed personnel (ULP)-C monitor R2's blood sugar with the FreeStyle Libre monitor (measures glucose through a sensor). R2's August 2024 Medication Administration Report (MAR), indicated R2 received blood glucose monitoring three times a day. R2's record did not include blood glucose parameters of when to notify the nurse or provider. On August 14, 2024, at 1:02 p.m., clinical nurse	01950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34608	A. BUILDING: _____ B. WING _____	08/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHT LIVING LLC	7309 ZANE AVENUE NORTH BROOKLYN PARK, MN 55443

(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
01950	Continued From page 87 supervisor (CNS)-B stated R2 did not have blood glucose parameters set of when to notify the nurse or provider because R2's provider had not put any blood glucose parameters in place. The licensee's Treatment and Therapy Management Plan policy dated February 15, 2022, indicated the licensee would prepare an individualized treatment or therapy management plan for each resident receiving orders or prescribed treatments or therapy services which addresses: -procedures for notifying the registered nurse or licensed health professional when a problem arises with treatment or therapy services. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950		
01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure written or electronically recorded orders were obtained for one of one resident (R2) who had treatments	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34608	A. BUILDING: _____ B. WING _____	08/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHT LIVING LLC	7309 ZANE AVENUE NORTH BROOKLYN PARK, MN 55443

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01970	Continued From page 88 managed by the provider. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2's diagnoses included schizophrenia and diabetes. R2's Service Plan dated July 22, 2022, did not include R2 received blood glucose (sugar) monitoring by the licensee. R2's August 2024 Medication Administration Report (MAR), indicated R2 received blood glucose monitoring three times a day. On February 14, 2024, at 9:38 a.m., clinical nurse supervisor (CNS)-B stated she was responsible for changing R2's Freestyle Libre sensor (a sensor that monitors blood glucose levels) every two weeks. On August 14, 2024, at 1:02 p.m., CNS-B stated she was unable to find treatment orders for R2's blood glucose monitoring and recently faxed R2's provider to obtain treatment and medication orders and was awaiting for a return fax. On August 14, 2024, at 2:39 p.m., the surveyor observed unlicensed personnel (ULP)-C monitor R2's blood glucose with the Libre monitor.	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34608	A. BUILDING: _____ B. WING _____	08/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHT LIVING LLC	7309 ZANE AVENUE NORTH BROOKLYN PARK, MN 55443

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01970	Continued From page 89 The licensee's Treatment and Therapy Management policy dated February 15, 2022, indicated the registered nurse (RN) or licensed health professional would obtain orders or prescriptions for all treatments and therapies. The order would include the following elements: -resident name; -description of the treatment or therapy to be provided; -frequency; and -other pertinent information. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970		

Minnesota Department of Health
Food, Pools and Lodging Services Section
625 N Robert St
St Paul, MN 55164
651-201-4500

Type: Follow-Up
Date: *08/20/24*
Time: 15:53:48
Report: 7963241090

Food and Beverage Establishment Inspection Report

Location:
Bright Living Llc
7309 Zane Avenue North
Brooklyn Park, MN55443
Hennepin County, 27

Establishment Info:
ID #: 0039388
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6128865744
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 previously issued on 08/13/24 have NOT been corrected.

2-100 Supervision

2-102.12AMN

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

NO CERTIFIED FOOD MANAGER CERTIFICATE ON SITE. FACT SHEET AND APPLICATION EMAILED WITH REPORT.

Issued on: 08/13/24 *Comply By: 08/13/24*

4-100 Equipment Construction Materials

4-101.19

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

LAMINATE COUNTERTOPS ARE IN POOR REPAIR AND HAVE EXPOSED WOOD IN PLACES. REPAIR/REPLACE.

Issued on: 08/13/24 *Comply By: 08/13/25*

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.11

MN Rule 4626.1515 Maintain the physical facilities in good repair.

LINOLEUM FLOORING IN BAD REPAIR. WOOD CABINET DOORS AND DRAWERS IN POOR CONDITION. REPAIR OR REPLACE.

Issued on: 08/13/24 *Comply By: 08/13/25*

Type: Follow-Up
Date: *08/20/24*
Time: 15:53:48
Report: 7963241090
Bright Living Llc

Food and Beverage Establishment Inspection Report

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.12A

MN Rule 4626.1520A Clean and maintain all physical facilities clean.

KITCHEN WALLS, FLOORS, CABINETS AND CEILING SOILED WITH FOOD, GREASE AND DIRT. CLEAN AND KEEP CLEAN.

Issued on: 08/13/24 *Comply By: 08/20/24*

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

Hot Water: = at 160 Degrees Fahrenheit
Location: dishwasher rinse
Violation Issued: No

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	0	0	4

FOLLOW-UP REPORT FROM 8/13/24 INSPECTION.

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 7963241090 of 08/20/24.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /

Inspection report reviewed with person in charge and emailed.

Signed:_____
Zaynab Isse

Signed:_____
Peggy Spadafore
Sanitarian Supervisor
metro
651-201-4500
peggy.spadafore@state.mn.us

Minnesota Department of Health
Food, Pools and Lodging Services Section
625 N Robert St
St Paul, MN 55164
651-201-4500

Type: Full
Date: *08/13/24*
Time: 14:20:32
Report: 7963241085

Food and Beverage Establishment Inspection Report

Location:
Bright Living Llc
7309 Zane Avenue North
Brooklyn Park, MN55443
Hennepin County, 27

Establishment Info:
ID #: 0039388
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6128865744
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.

4-700 Sanitizing Equipment and Utensils

4-702.11 ***** Priority 1 *****

MN Rule 4626.0900 Sanitize utensils and food contact surfaces of equipment before use, after cleaning.

UNABLE TO VERIFY IF DISHWASHER REACHED AT 160 DEG F SURFACE TEMP FOR DISHES AND UTENSILS. TEST STICKER LEFT WITH ESTABLISHMENT.

Comply By: 08/13/24

6-300 Physical Facility Numbers and Capacities

6-301.11 ***** Priority 2 *****

MN Rule 4626.1440 Provide an adequate supply of hand soap at each handwashing sink or group of 2 adjacent handwashing sinks.

NO SOAP AVAILABLE FOR HAND WASHING AT EITHER KITCHEN SINK OR BATHROOM SINK. CORRECTED ON SITE.

Corrected on Site

2-100 Supervision

2-102.12AMN

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

NO CERTIFIED FOOD MANAGER CERTIFICATE ON SITE. FACT SHEET AND APPLICATION EMAILED WITH REPORT.

Comply By: 08/13/24

4-100 Equipment Construction Materials

4-101.19

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

LAMINATE COUNTERTOPS ARE IN POOR REPAIR AND HAVE EXPOSED WOOD IN PLACES. REPAIR/REPLACE.

Comply By: 08/13/25

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.11

MN Rule 4626.1515 Maintain the physical facilities in good repair.

LINOLEUM FLOORING IN BAD REPAIR. WOOD CABINET DOORS AND DRAWERS IN POOR CONDITION. REPAIR OR REPLACE.

Comply By: 08/13/25

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.12A

MN Rule 4626.1520A Clean and maintain all physical facilities clean.

KITCHEN WALLS, FLOORS, CABINETS AND CEILING SOILED WITH FOOD, GREASE AND DIRT. CLEAN AND KEEP CLEAN.

Comply By: 08/20/24

Food and Equipment Temperatures

Process/Item: MILK
Temperature: 40 Degrees Fahrenheit - Location: REFRIGERATOR
Violation Issued: No

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	1	1	4

MET WITH ZAYNAB ISSE AND MDH NURSE SURVEYOR SATIVA BUSHEY. DISCUSSED THE FOLLOWING-

-EMPLOYEE ILLNESS POLICY AND LOG
-REPORTABLE DISEASES
-HIGHLY SUSCEPTIBLE POPULATIONS REQUIREMENTS
-REQUIREMENTS FOR WASHING AND SANITIZING DISHES

THIS IS A RESIDENTIAL KITCHEN.

CEILING IS POPCORN TEXTURE, WOOD CABINETS, LAMINATE COUNTERTOP AND LAMINATE FLOOR.

Type: Full
Date: *08/13/24*
Time: 14:20:32
Report: 7963241085
Bright Living Llc

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 7963241085 of 08/13/24.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /

Inspection report reviewed with person in charge and emailed.

Signed:_____
ZAYNAB ISSE

Signed:_____
Peggy Spadafore
Sanitarian Supervisor
metro
651-201-4500
peggy.spadafore@state.mn.us

Report #: 7963241085

Food Establishment Inspection Report

Minnesota Department of Health
Food, Pools and Lodging Services Section
625 N Robert St
St Paul, MN 55164

No. of RF/PHI Categories Out	3	Date	08/13/24
No. of Repeat RF/PHI Categories Out	0	Time In	14:20:32
Legal Authority MN Rules Chapter 4626		Time Out	

Bright Living Llc	Address: 7309 Zane Avenue North	City/State: Brooklyn Park, MN	Zip Code: 55443	Telephone: 6128865744
License/Permit #: 0039388	Permit Holder	Purpose of Inspection: Full	Est Type	Risk Category

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item — Mark "X" in appropriate box for COS and/or R

IN= in compliance **OUT=** not in compliance **N/O=** not observed **N/A=** not applicable **COS=** corrected on-site during inspection **R=** repeat violation

Compliance Status						COS	R
Surpervision							
1	(IN)	OUT			PIC knowledgeable; duties & oversight		
2	IN	(OUT)	N/A		Certified food protection manager, duties		
Employee Health							
3	(IN)	OUT			Mgmt/Staff;knowledge,responsibilities&reporting		
4	(IN)	OUT			Proper use of reporting, restriction & exclusion		
5	(IN)	OUT			Procedures for responding to vomiting & diarrheal events		
Good Hygenic Practices							
6	(IN)	OUT		N/O	Proper eating, tasting, drinking, or tobacco use		
7	(IN)	OUT		N/O	No discharge from eyes, nose, & mouth		
Preventing Contamination by Hands							
8	(IN)	OUT		N/O	Hands clean & properly washed		
9	IN	OUT	N/A	(N/O)	No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed		
10	IN	(OUT)			Adequate handwashing sinks supplied/accessible	X	
Approved Source							
11	(IN)	OUT			Food obtained from approved source		
12	IN	OUT	N/A	(N/O)	Food received at proper temperature		
13	(IN)	OUT			Food in good condition, safe, & unadulterated		
14	IN	OUT	(N/A)	N/O	Required records available; shellstock tags, parasite destruction		
Protection from Contamination							
15	(IN)	OUT	N/A	N/O	Food separated and protected		
16	IN	(OUT)	N/A		Food contact surfaces: cleaned & sanitized		
17	(IN)	OUT			Proper disposition of returned, previously served, reconditioned, & unsafe food		

Compliance Status						COS	R
Time/Temperature Control for Safety							
18	IN	OUT	N/A	(N/O)	Proper cooking time & temperature		
19	IN	OUT	N/A	(N/O)	Proper reheating procedures for hot holding		
20	IN	OUT	N/A	(N/O)	Proper cooling time & temperature		
21	IN	OUT	N/A	(N/O)	Proper hot holding temperatures		
22	(IN)	OUT	N/A		Proper cold holding temperatures		
23	(IN)	OUT	N/A	N/O	Proper date marking & disposition		
24	IN	OUT	(N/A)	N/O	Time as a public health control: procedures & records		
Consumer Advisory							
25	IN	OUT	(N/A)		Consumer advisory provided for raw/undercooked food		
Highly Susceptible Populations							
26	(IN)	OUT	N/A		Pasteurized foods used; prohibited foods not offered		
Food and Color Additives and Toxic Substances							
27	IN	OUT	(N/A)		Food additives: approved & properly used		
28	(IN)	OUT			Toxic substances properly identified, stored, & used		
Conformance with Approved Procedures							
29	IN	OUT	(N/A)		Compliance with variance/specialized process/HACCP		

Risk factors (RF) are improper practices or proceedures identified as the most prevalent contributing factors of foodborne illness or injury. **Public Health Interventions** (PHI) are control measures to prevent foodborne illness or injury.

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" in box if numbered item is **not** in compliance — Mark "X" in appropriate box for COS and/or R — **COS=** corrected on-site during inspection **R=** repeat violation

					COS	R
Safe Food and Water						
30	IN	OUT	(N/A)	Pasteurized eggs used where required		
31				Water & ice obtained from an approved source		
32	IN	OUT	(N/A)	Variance obtained for specialized processing methods		
Food Temperature Control						
33				Proper cooling methods used; adequate equipment for temperature control		
34	IN	OUT	N/A (N/O)	Plant food properly cooked for hot holding		
35	IN	OUT	N/A (N/O)	Approved thawing methods used		
36				Thermometers provided & accurate		
Food Identification						
37				Food properly labled; original container		
Prevention of Food Contamination						
38				Insects, rodents, & animals not present		
39				Contamination prevented during food prep, storage & display		
40				Personal cleanliness		
41				Wiping cloths: properly used & stored		
42				Washing fruits & vegetables		

			COS	R
Proper Use of Utensils				
43		In-use utensils: properly stored		
44		Utensils, equipment & linens: properly stored, dried, & handled		
45		Single-use/single service articles: properly stored & used		
46		Gloves used properly		
Utensil Equipment and Vending				
47	X	Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48		Warewashing facilities: installed, maintained, & used; test strips		
49		Non-food contact surfaces clean		
Physical Facilities				
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities: properly constructed, supplied, & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55	X	Physical facilities installed, maintained, & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing & plan review		

Food Recalls:

Person in Charge (Signature) **Date:** 08/14/24

Inspector (Signature) Peggy Spudy