Electronically Delivered

August 30, 2024

Licensee
H And S Residence LLC
532 79th Avenue North
Brooklyn Park, MN 55444

RE: Project Number(s) SL36081015

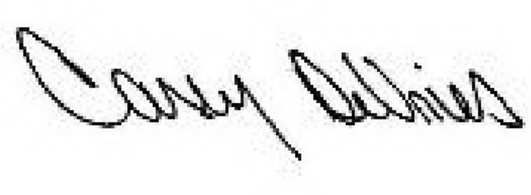
Dear Licensee:

On August 7, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the June 26, 2024, survey were corrected. This follow-up survey verified that the facility is back in compliance.

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

Please feel free to call me with any questions.

Sincerely,



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

JMD

Electronically Delivered

July 24, 2024

Licensee
H&S Residence LLC
532 79th Avenue North
Brooklyn Park, MN 55444

RE: Project Number(s) SL36081015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on June 26, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

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

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

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

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

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

1290 - 144g.60 Subdivision 1 - Background Studies Required - $3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $3,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the

correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. to submit a hearing request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

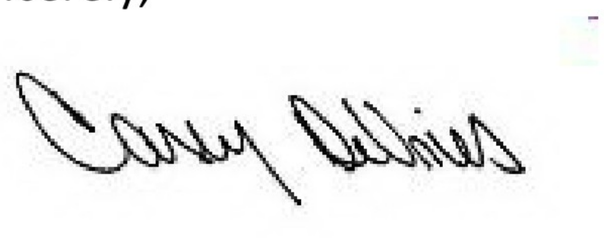
To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms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

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,



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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36081	A. BUILDING: _____ B. WING _____	06/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
H AND S RESIDENCE LLC	532 79TH AVENUE NORTH BROOKLYN PARK, MN 55444

(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: SL36081015-0 On June 24, 2024, through June 26, 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; two of whom received services under the provider's Assisted Living license. 1290: An immediate correction order was identified on June 24, 2024, at a level 3, Isolated (G). The immediacy was removed on June 25, 2024, but deficiency remains at the same scope/level of G.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for	0 470		

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0 470	Continued From page 1 determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the staff schedule was posted as required, potentially affecting the licensee's current resident, staff, and visitors. Additionally, the licensee failed to develop and implement an accurate written staffing plan that included an evaluation completed by the clinical nurse supervisor (CNS) (as indicated in Minnesota Administrative Rule 4659.0180) at least twice a year.	0 470		

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0 470	Continued From page 2 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: STAFF SCHEDULE POSTING On June 24, 2024, at approximately 10:10 a.m., during facility tour, the surveyor observed multiple documents titled Employee Shift Schedule dated August 26, 2023, through September 30, 2023, December 2023, January 2024, and February 2024 posted on the wall near the kitchen area. Assisted living director (ALD)-D stated the staff schedules posted were "out of date and they mainly use text" to communicate scheduling. ALD-D stated they communicated in a group message via text about the schedule to ensure coverage at the facility 24 hours per day. The surveyor inquired how residents and visitors knew the staff coverage of the facility. ALD-D stated residents or visitor could ask the staff member who was working at the facility. STAFFING PLAN On June 24, 2024, at 9:10 a.m. during the entrance conference, assisted living director (ALD)-D stated one unlicensed personnel (ULP) worked each shift. ALD-D stated the licensee's shifts included 9:00 p.m. to 9:00 a.m., 9:00 a.m. to 3:00 p.m., and 3:00 p.m. to 9:00 p.m. In addition, ALD-D stated the nurse worked at the facility one time per week with varying hours.	0 470		

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0 470	Continued From page 3 The licensee's Staffing Pan signed by CNS-C on March 23, 2024, indicated there would be a minimum of one awake staff member per shift and an occasional additional staff member to assist with resident needs. Other staff members not scheduled for the shift would be available for on-call duties in case a scheduled employee called off and the administrator would provide staff coverage if the on-call was not available to work. The CNS was available 24 hours per day and the nurse supervisor was the backup in case the CNS was unavailable. In addition, the shifts were 8-hour shifts Monday through Friday 7:00 a.m. to 3:00 p.m., 3:00 p.m. to 11:00 p.m., and 11:00 p.m. to 7:00 a.m. and on weekends twelve hour shifts 7:00 a.m. to 7:00 p.m. and 7:00 p.m. to 7:00 a.m. The licensee's current staffing plan did not reflect the type of staff member working, and the current shift staff members work location. In addition, the surveyor did not receive additional documents throughout the survey to show the CNS evaluated the staffing plan twice per year. On June 25, 2024, at 1:34 p.m., CNS-C stated the licensee communicated the staff schedule by phone via text message; however, ALD-D was responsible for printing out the schedule and posting it. CNS-C stated the licensee's shifts were from 9:00 p.m. to 9:00 a.m., 9:00 a.m. to 3:00 p.m., and 3:00 p.m. to 9:00 p.m. CNS-C stated ULP shifts used to be 12 hours long; however, the licensee changed the shifts to shorter periods of time to accommodate staff member's needs. The surveyor inquired why the staffing plan was not updated to reflect this. CNS-C stated they were unsure why they did not update the staffing plan. The licensee's Staffing policy dated July 11, 2022,	0 470		

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0 470	Continued From page 4 indicated the CNS-S would prepare and implement a 24-hour daily staffing plan that ensures adequate staffing to meet the resident needs at all times including reasonably foreseeable needs. The staffing plan would consider the number of direct-care staff to meet the needs of the resident throughout the day and night. In addition, a daily staffing schedule was prepared by the CNS and addressed the ULP work schedules for each ULP showing work shifts with days and hours worked and would be posted at the beginning of the shift in a central location. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		
0 630 SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include	0 630		

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0 630	Continued From page 5 the required content 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 admitted to the licensee on April 24, 2021, under the licensee's former comprehensive home care license and began receiving assisted living services on August 1, 2021. R2's Service Plan (Wavier)-Addendum to Contract signed January 3, 2024, indicated R2 received assistance with appointment reminders, bathing reminders, housekeeping, laundry, behavior management, meals, medication administration, and shopping assistance. R2's ongoing nursing assessment dated June 4, 2024, included R2's IAPP. The assessment indicated R2 was verbally aggressive, hallucinated, self-isolated, had anxiety attacks, and had a history of drug and alcohol use at the facility. The assessment indicated R2 was at risk to be abused by others however lacked an individualized review or assessment of the resident's risk of abusing other vulnerable adults and the statement of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. On June 24, 2024, at 2:04 p.m., clinical nurse	0 630		

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0 630	Continued From page 6 supervisor (CNS)-C stated R2 was not at risk to abuse others because R2 was vulnerable and shy. CNS-C opened R2's most recent assessment dated June 4, 2024, on RTasks (a documenting software program) and the surveyor observed a section that contained three questions which inquired if the resident was at risk to abuse others, if the resident was not at risk to abuse others, and if the resident was at risk to abuse self. The surveyor observed the box marked next to the question if the resident was at risk to abuse self and the other two questions did not have a mark by them. CNS-C stated they believed they just had to pick one from the section to meet the requirement and they picked the question that best applied to R2. The licensee's Vulnerable Adult Policy dated July 11, 2022, read, "An individual abuse prevention plan shall be established for each vulnerable minor or adult for whom assisted living services are provided. 1) The plan shall contain an individualized assessment of the resident' susceptibility to abuse by another individual, including other vulnerable adults 2) The plan shall contain the resident's risk of abusing other vulnerable adults 3) The plan shall contain statements of specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. 4) The plan will be implemented immediately and evaluated at each supervisory visit or more frequently, if necessary." No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		

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0 650	Continued From page 7	0 650		
0 650 SS=F	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employee records contained the required content for four of four employees (clinical nurse supervisor (CNS)-C, unlicensed personnel (ULP)-A, ULP-E, ULP-F). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	0 650		

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0 650	Continued From page 8 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: CNS-C CNS-C was hired on September 24, 2020, to provide supervision to ULP and provide direct cares and services to residents. CNS-C's employee record lacked evidence of the following required content: - documentation of annual performance reviews that identify areas of improvement needed and training needs; - current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; and - orientation to include overview of assisted living statues, review of types of assisted living services the employee would provide and provider's scope of license, and principles of person-centered planning/service delivery. ULP-A ULP-A was hired on September 24, 2020, to provide direct cares and services to residents. ULP-A's employee record lacked evidence of the following required content: - documentation of annual performance reviews that identify areas of improvement needed and training needs. ULP-E ULP-E was hired on October 2, 2022, to provide direct cares and services to residents.	0 650		

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0 650	Continued From page 9 ULP-E's employee record lacked evidence of the following required content: - documentation of annual performance reviews that identify areas of improvement needed and training needs. ULP-F ULP-F was hired on November 1, 2022, to provide direct cares and services to residents. ULP-F's employee record lacked evidence of the following required content: - documentation of annual performance reviews that identify areas of improvement needed and training needs. On June 25, 2024, at 8:13 a.m., CNS-C stated they had additional training at their other place of employment. Although CNS-C provided trainings from their other place of employment, components of orientation are non-transferable and the trainings did not cover the orientation topics listed above. On June 25, 2024, at 9:38 a.m., assisted living director (ALD)-D stated performance evaluations should be completed once per year and be kept in the employee record. ALD-D stated they knew all employee's performance evaluations were completed in 2022. ALD-D showed the surveyor a yellow binder that showed all position descriptions. The position descriptions were not in the employee file. ALD-D further stated orientation was completed on EduCare (a training software). On June 25, 2024, at 1:00 p.m., ALD-D stated CNS-C did not have the orientation listed above in their record because they believed it was not	0 650		

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0 650	Continued From page 10 needed since CNS-C was a partial owner of the company. CNS-C stated when the comprehensive license converted to an assisted living license, they reviewed the statues and the scope of practice and even bought the assisted living statue book to review. CNS-C stated they received all of the required orientation listed above; however, they did not document the training in the employee record. On June 26, 2024, at 9:09 a.m., ALD-D stated, "my record keeping is not good." ALD-D stated CNS-C was responsible for performance reviews for ULP. CNS-C stated they believe they completed a performance review for the ULP first year of employment; however, they did not complete performance evaluations after the first year of the assisted living licensure. The licensee's Personnel Record policy dated July 11, 2022, read, "2. At a minimum, all documents related to the following are kept in the personnel record, as applicable to job requirements o Evidence of current professional licensure, registration or certification o Results of background studies o Records of annual training and infection control training o Documentation of orientation o Documentation of supervision, as applicable o Performance reviews o Competency evaluations o Signed job description o Documentation of annual performance reviews identifying areas of improvement needed and training needs" No further information was provided.	0 650		

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	36081	A. BUILDING: _____ B. WING _____	06/26/2024

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0 650	Continued From page 11 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a written emergency preparedness plan (EPP) with all the required content as defined in Appendix Z. This had the potential to affect all residents, staff, and visitors.	0 680		

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0 680	Continued From page 12 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's emergency disaster preparedness plan lacked evidence of the following required content: - strategies for addressing facility and community-based risks to include staffing surges/shortages and back up plans; - quarterly review of missing resident policy; - arrangement with other facilities to include arrangement agreements; - long term care family notifications; and - emergency prep testing requirements. On June 25, 2024, at 8:50 a.m., assisted living director (ALD)-D stated if there were a staffing shortage, the licensee had a backup assisted living facility who would assist, and they used the tree diagram for their staff of who would need to come in. The surveyor inquired if they had documentation related to the other assisted living facility assisting the licensee for staffing shortages. ALD-D stated "no." ALD-D stated they reviewed the missing resident policy once per year and was unaware they needed to review it quarterly. ALD-D stated they had an arrangement with another assisted living facility in case an evacuation was needed; however, they only had a verbal agreement and did not have anything in	0 680		

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0 680	Continued From page 13 writing. On June 25, 2024, at 9:21 a.m., ALD-D stated they completed a tornado drill in February 2024; however, they did not document the drill. ALD-D stated, "I am sorry. I must have forgot to put it. I can add it." The licensee's Emergency Preparedness policy dated July 11, 2022, indicated the licensee would have an identified plan in place to assure the safety and well-being of resident and staff during periods of emergency or disaster that disrupts services. In addition, a disaster drill would be conducted at the facility annually and the results of the drill will be documented. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics;	0 780		

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0 780	Continued From page 14 (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: On a facility tour on June 25, 2024, at 1:20 p.m., with assistant director (ALD-D), it was observed that the smoke alarms located inside the resident sleeping rooms one, two, three, and four, were not interconnected so activation of the alarms activates all alarms throughout the facility. Smoke alarms are required to be installed inside and outside in the immediate vicinity of all sleeping rooms. All smoke alarms are required to	0 780		

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0 780	Continued From page 15 be interconnected so activation of one alarm activates all alarms throughout the facility. During the tour the smoke alarms were tested and ALD-D, verified the resident sleeping room smoke alarms were not interconnected so activation of one alarm activates all alarms throughout the facility. ALD-D verified they understood the requirement and would have a new smoke alarms installed. 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 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	0 800		

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0 800	Continued From page 16 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). Findings include: On a facility tour on June 25, 2024, at 1:20 p.m., with assistant director (ALD-D), the following was observed: It was observed that rear deck had one step that was loose and broken. There was also one step that was loose and slanted. Loose, broken steps create a trip hazard. It was observed that the guard rail at the bottom of the rear deck steps was loose. Guardrails must be maintained to prevent accidental falls from elevated surfaces and stairs. ALD-D stated they were not aware the guard was loose, and they would have someone repair it. It was observed that there was a hole in the wall in resident room 4 on the main floor. It was observed that the door into resident room 3 on the main floor was not latching properly, and the latch side jamb was not attached to the wall. ALD-D stated that the resident had slammed the door and damage it. ALD-D visually verified these deficient findings at the time of discovery. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 800		

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0 810	Continued From page 17	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: Based on observation, interview, and record	0 810		

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0 810	Continued From page 18 review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required training and drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On June 25, 2024, at 1:45 p.m., assistant director (ALD-D) provided documentation 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's FSEP, titled "Fire Safety", dated July 11, 2022 failed to include the following: The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate) but the plan was designed for a building with life safety systems such as manual fire alarms. The policy had not been updated to provide complete actions for employees to take in the event of a fire or similar emergency at the licensed facility which did not	0 810		

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0 810	Continued From page 19 have life safety systems stated in the policy. The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. The FSEP included standard resident evacuation procedures but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency. The plan included instructions to evacuate residents but did not include any procedures for assisting residents during evacuation. During an interview on June 25, 2024, at 2:00 p.m., ALD-D stated they understood the areas of the FSEP that need to be updated. TRAINING Record review indicated the licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. ALD-D provided documentation showing training was provided once in 2022, once in 2023 and no trainings in 2024. Training on the fire safety and evacuation plan is required for staff at hire and at least twice annually thereafter. During an interview on June 25, 2024, at 2:00 p.m., ALD-D stated they thought the fire drills would count as training. Survey staff explained that fire drills are different and that staff should receive training specific to the FSEP. DRILLS	0 810		

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0 810	Continued From page 20 Record review indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month. ALD-D provided documentation indicating that drills were completed in January and July in 2023 and February in 2024 but no other drills were provided. During an interview on June 25, 2024, at 2:00 p.m., survey staff explained the requirements for frequency of drills. ALD-D stated they understood the requirements. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01290 SS=G	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	01290		

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01290	Continued From page 21 review, the licensee failed to ensure a background study was submitted and received in affiliation with the assisted living license for one of nine employees (business coordinator (BC)-B). This resulted in an immediate correction order issued on June 25, 2024. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The finding include: BC-B was hired on August 3, 2020, as an unlicensed personnel to provide direct cares and services and then transitioned to director of the facility for eleven months between 2022 and 2023. In 2023, BC-B transitioned positions for the licensee and became a billing coordinator. On June 25, 2024, at 7:37 a.m., the surveyor compared the facility's employee list to licensee's Minnesota (MN) Department of Human Services (DHS) NETStudy 2.0 roster for Health facility identification (HFID) 36081 and observed BC-B's background study affiliated to licensee's health facility identification number (HFID) 36081 indicated "Eligible - COVID-19 Study - Expired" with an expiration date of December 31, 2022, on the Minnesota Department of Human Services NETStudy 2.0 website (a web-based system used to submit background study requests) roster page.	01290		

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01290	Continued From page 22 On June 25, 2024, at 8:44 a.m., assisted living director (ALD)-D stated BC-B only completed billing for the licensee. ALD-D stated BC-B worked from home on their personal laptop. On June 25, 2024, at 9:28 a.m., clinical nurse supervisor (CNS)-C stated the licensee's old NetStudy account changed when the comprehensive license changed to an assisted living license. ALD-D stated they did not re-run a background study on BC-B because they were not working at the facility. ALD-D stated they re-ran all other employees background studies who had COVID expired studies that worked at the facility. On June 25, 2024, at 9:52 a.m., ALD-D stated BC-B entered information into "Minutes portal" so the licensee could receive payments for services provided. ALD-D stated the portal did not have information including social security numbers or bank account numbers with the exception of the licensee's bank account and used a code to enter the information. ALD-D stated BC-B did however have access to resident information in RTasks (a documenting software program) to input the correct billing information. On June 25, 2024, at 10:23 a.m., ALD-D provided another NetStudy 2.0 roster which indicated BC-B was affiliated to HFID 36081 on June 25, 2024. On June 25, 2024, at 10:55 a.m., ALD-D provided the surveyor with a paycheck deposit for BC-B for contract labor. The surveyor then observed the Minnesota Board of Executives for Long Term Services and Supports (BELTSS) website and observed BC-B's residency permit expired on June 12, 2023.	01290		

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01290	Continued From page 23 On June 25, 2024, at 11:26 a.m., via email correspondence, a BELTSS representative indicated BELTSS completes a criminal background check (CBC) when a person applies for a residency permit, however the permit is only good for twelve months, and after twelve months, both the permit and criminal background check expire. The email indicated BC-B's CBC expired on June 30, 2022, and was not renewed because BC-B did not obtain their Assisted Living Director's license. The email indicated BC-B would need to have a current background study through NetStudy for their employment at the licensee's HFID 36081. The licensee's undated 4.02 Background Studies policy indicated the licensee would conduct a Minnesota Department of Human Services background study on all employees, volunteers, and contractors. On June 25, 2024, the Minnesota Department of Human Services website indicated the following: Emergency studies completed during the COVID-19 pandemic were no longer valid. Individuals who only had an emergency study must have a fully compliant, fingerprint-based background study. Roster maintenance - Individuals with a completed emergency study will remain on the entity's roster unless the entity removes the individual. Entities should remove individuals with emergency studies that are no longer affiliated; - If the individual should no longer be affiliated and has a new fully compliant background study, the entity should wait until the individual is separated and then remove both the emergency study and fully compliant study from their roster at the same time;	01290		

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01290	Continued From page 24 - All entities are responsible for maintaining their rosters regularly and removing study subjects from their roster when they are no longer affiliated; and - Entities are responsible for identifying who needs to submit a new background study. For help identifying which study subjects still have an emergency study and need a fully compliant study, entities should refer to the instructional guide, "Identifying Emergency Studies" in the help section of NETStudy 2.0. No further information provided. TIME PERIOD FOR CORRECTION: Immediate The immediacy was lifted on June 25, 2024; however, the deficiency remains at a scope and level of G.	01290		
01500 SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal	01500		

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01500	Continued From page 25 of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions.	01500		

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01500	Continued From page 26 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure three of four employees (unlicensed personnel (ULP)-A, ULP-E and ULP-F) received at least eight hours of training for each 12 months of employment. 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: ULP-A ULP-A was hired on September 24, 2020, to provide direct cares and services to residents. On June 25, 2024, at 9:03 a.m. the surveyor observed ULP-A administer oral medications to R1 and R2. ULP-E ULP-E was hired on October 2, 2022, to provide direct cares and services to residents. ULP-F ULP-F was hired on November 1, 2022, to provide direct cares and services to residents. ULP-A, ULP-E, and ULP-F's employee records included eight hours of annual training last completed on February 3, 2023. ULP-A, ULP-E, ULP-F's employee records lacked documentation	01500		

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01500	Continued From page 27 of eight hours of annual training completed within the last 12 months, including the following required topics: - training on reporting of maltreatment of vulnerable adults under section 626.557; - review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; -review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; - effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; - review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. On June 25, 2024, at 9:38 a.m., ALD-D stated employees completed eight hours of education annually. ALD-D stated all employees completed eight hours of EduCare (a training software program) annually. On June 25, 2024, at 1:06 p.m., ALD-D stated they were unable to find documentation of ULP-A's annual training. ALD-D stated RTasks (a	01500		

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01500	Continued From page 28 documenting software program) had reminders to complete annual training. ALD-D stated they created a sheet for staff to sign after they reviewed the licensees policies and procedures; however, they believe someone removed it from the policy book. ALD-D stated annual training was completed in EduCare and they believe it populated the training for the employees to complete when it was due. On June 25, 2024, at 1:17 p.m., ALD-D opened EduCare on the computer to see what ULP-A had completed for annual training. The surveyor observed annual training course work assigned but not completed. On June 26, 2024, at 7:46 a.m., CNS-C stated they assigned annual training to all other staff members in EduCare; however, they did not know if the employees completed all of the trainings. On June 26, 2024, at 8:36 a.m., ALD-D stated they were responsible for enforcing staff to complete required annual training. ALD-D stated they had multiple meetings throughout the year to train staff on different topics; however, they did not document any of the meeting's minutes. ALD-D stated, "to be honest, meeting with them, training them, is what I thought I should do every year." ALD-D stated she recently learned from their mentor in April 2024, that what they had been providing for annual education was not correct. ALD-D stated they contacted EduCare in April 2024, to provide the licensee with the required annual training and have assigned the correct training in the computer; however, many of the employees still needed to complete the annual training. ALD-D provided the surveyor with emails from EduCare to the licensee related to	01500		

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01500	Continued From page 29 training. The licensee's Staff Orientation and Education dated July 11, 2022, indicated all staff providing assisted living services would complete at least eight hours of education for every 12 months of employment and the education topics would include the following: - reporting of maltreatment of adults; - review of Assisted Living Bill of Rights and staff responsibilities related to ensuring the exercise and protection of those rights; - review of the organization's policies and procedures related to provision of assisted living services and how to implement them; - infection control techniques used in the home; - implementation of infection control standards based on current recommendations per the CDC for hand washing techniques and need for/use of personal protective equipment (PPE), appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes and razor blade, disinfection of reusable equipment, disinfection of environmental surfaces, and reporting of communicable diseases; - effective approaches to use to problem solve when working with a resident's challenging behaviors and how to communicate with residents who have dementia, Alzheimer's Disease or related disorders; and - the principles of person-centered planning and service delivery and how they apply to direct support services provided by staff. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		

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01750	Continued From page 30	01750		
01750 SS=D	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the registered nurse (RN) failed to specify in writing, specific instructions for one of two residents (R1) related to medication administration. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 admitted to the licensee on February 24, 2022, and began receiving assisted living services.	01750		

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01750	Continued From page 31 R1's Service Plan (Wavier)-Addendum to Contract signed October 3, 2023, indicated R1 received assistance with medication administration. On June 25, 2024, at 9:06 a.m., the surveyor observed ULP-A administer oral medications to R1. R1's prescriber orders signed June 14, 2024, included Ventolin inhaler-inhale one to two puffs by mouth every six hours as needed (PRN) for wheezing or shortness of breath. R1's Med Admin-Summary- Month dated June 1, 2024, through June 30, 2024, included Ventolin inhaler-inhale one to two puffs by mouth every six hours PRN for wheezing or shortness of breath. The electronic medication administration record (EMAR) lacked specific instructions of when to administer one puff verses two puffs of Ventolin. R1's Individualized Medication Assessment and Management Plan completed June 4, 2024, indicated R1 was unable to self-administer medications, inhaler and oral medications may be delegated to unlicensed personnel (ULP), and staff to contact on call nurse by phone with questions or concerns related to medications. On June 24, 2024, clinical nurse supervisor (CNS)-C stated R1 would receive two puffs of Ventolin if they were gasping for air and one puff if they complained of shortness of breath. CNS-C stated staff should call the on-call nurse prior to administering PRN medications to get further instruction on what to administer. The licensee's Medication Administration policy	01750		

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01750	Continued From page 32 dated July 11, 2022, indicated the registered nurse (RN) may delegate medication administration to a ULP according to the following protocol: - all home health aides have passed a competency evaluation with respect to all medication routes to be administered; - the RN has prepared written instructions for the home health aide in proper methods to administer medication with respect to each resident; and - the RN has communicated and provided orientation to the ULP regarding the individual needs of the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		
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 33 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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01790	Continued From page 34 doses of each returned medication. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) developed training and competencies for three of three unlicensed personnel (ULP-A, ULP-E, ULP-F) providing medications to residents for unplanned time away from home 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-A ULP-A was hired on September 24, 2020, to provide direct cares and services to residents. ULP-E ULP-E was hired on October 2, 2022, to provide direct cares and services to residents. ULP-F ULP-F was hired on November 1, 2022, to provide direct cares and services to residents. R2 admitted to the licensee on April 24, 2021, and began receiving assisted living services. R2's Service Plan (Wavier)-Addendum to Contract signed January 3, 2024, indicated R2	01790		

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01790	Continued From page 35 received assistance with medication administration. R2 medical record included multiple untitled, documents signed on March 8, 2024, by ULP-A and R2 and on May 18, 2024, by ULP-F and R2, indicating the ULP provided R2 with medication for an unplanned time away from home. ULP-A, ULP-E, and ULP-F's employee record lacked documentation of training and competencies for unplanned time away when the RN is not available. On June 25, 2024, at 1:47 p.m., clinical nurse supervisor (CNS)-C stated staff were trained on how to release medication to the resident and place the resident chart on hold for times when they were away. CNS-C stated they did not have documentation for any ULP related to training or complete competencies for unplanned time away from home. The licensee's Medication Management Plan for Residents Away From Home policy dated July 11, 2022, indicated for unplanned times away from home for temporary periods, the RN may delegate to a ULP to provide medication if the RN has trained the ULP and determined the ULP was competent to follow procedures for giving medications to residents. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790		
02290 SS=F	144G.91 Subd. 2 Legislative intent	02290		

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02290	Continued From page 36 The rights established under this section for the benefit of residents do not limit any other rights available under law. No facility may request or require that any resident waive any of these rights at any time for any reason, including as a condition of admission to the facility. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee limited the rights of residents when the licensee required all residents who resided in the facility to follow certain house rules. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 R1 admitted to the licensee on February 24, 2022, and began receiving assisted living services. R1's Service Plan (Wavier)-Addendum to Contract signed October 3, 2023, indicated R1 received assistance with ambulation, appointment reminders, bathing reminders, laundry, behavior management, meals, and medication administration. R2 R2 admitted to the licensee on April 24, 2021, and under the licensee's former comprehensive	02290		

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02290	Continued From page 37 home care license and began receiving assisted living services on August 1, 2021. R2's Service Plan (Wavier)-Addendum to Contract signed January 3, 2024, indicated R2 received assistance with appointment reminders, bathing reminders, housekeeping, laundry, behavior management, meals, medication administration, and shopping assistance. R1 and R2's medical record included a document titled Lease Addendum for Crime-Free Alcohol/Beer/Illegal Drug-Free Housing signed March 3, 2023, and March 14, 2022, respectively. The document indicated no alcohol was allowed at the facility and failure to do so would be cause for termination of tenancy. The document indicated R1 and R2 agreed to the information listed on the document. On June 25, 2024, at 1:40 p.m., clinical nurse supervisor (CNS)-C stated if they had a prescription for cannabis, they would allow the resident to have it in the facility; however, the licensee would have to develop a policy. CNS-C stated they did not allow alcohol in the facility for safety reasons. CNS-C stated all residents are aware and agree to the rules prior to admission. CNS-C stated they were unaware this violated resident rights. On June 26, 2024, at 8:43 a.m., assisted living director (ALD)-D stated, "house rules is simple no drinking smoking in the house or surrounding area." ALD-D stated staff help residents follow the rules. ALD-D stated the licensee started the house rules because of a resident who had an alcohol problem and became verbally and physically aggressive when they used alcohol. ALD-D stated they were unaware this violated	02290		

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02290	Continued From page 38 resident's rights. The licensee's undated, Minnesota Assisted Living Bill of Rights indicated the licensee could not request or require a resident to waive any of their rights at any time for any reason, including a condition of admission to the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02290		
02320 SS=F	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure unlicensed personnel (ULP-A) followed appropriate medication administration procedures for all residents currently residing within 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	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36081	A. BUILDING: _____ B. WING _____	06/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
H AND S RESIDENCE LLC	532 79TH AVENUE NORTH BROOKLYN PARK, MN 55444

(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
02320	Continued From page 39 of the residents). The findings include: ULP-A was hired on September 24, 2020, to provide direct cares and services to residents. ULP-A's employee record included medication training completed on September 1, 2020, and medication competency completed on September 15, 2020, (ULP-A is a partial owner of the company and received training and competencies prior to the date of hire at the facility to gain knowledge of the business). The medication competency indicated ULP-A was trained to verify there was the right number of medications in the medication box prior to administration. On June 24, 2024, at 9:35 a.m., clinical nurse supervisor (CNS)-C stated staff were trained to use RTasks (a documenting software program) when completing a medication pass. CNS-C stated ULP were to open the electronic medication administration record (EMAR), compare the medications against the EMAR, then document in the EMAR once the medications were administered. CNS-C stated ULP took a refresher training on medication administration every six months, and they trained staff when a new medication was added to a resident's regimen. On June 24, 2024, at 10:24 a.m., the surveyor observed the medication cabinet and observed the following medications in the morning medication blister packs: -R1: 200 milligrams (mg) carbamazepine, 80 mg of fluoxetine, 25 mg of hydroxyzine, 1 multivitamin, 1 vitamin D3 1,000 units (u); and -R2: aripiprazole 5 mg, escitalopram 5 mg, and	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36081	A. BUILDING: _____ B. WING _____	06/26/2024

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02320	Continued From page 40 omeprazole 20 mg. R1's Med Admin Summary - Month dated June 2024, included the following morning medications: Advair inhaler one puff, carbamazepine 200 mg, fluoxetine 80 mg, hydroxyzine 25 mg, multivitamin one tablet, vitamin D3 1000 u, and one clonidine patch every Sunday. R2's Med Admin Summary - Month dated June 2024, included the following morning medications: aripiprazole 5 mg, escitalopram 5 mg, omeprazole 20 mg. On June 25, 2024, at 9:03 a.m. the surveyor observed ULP-A wash their hands, apply gloves, log into the computer, walk over to and open the medication cabinet, take out R1's morning blister packet scheduled for the day, and dumped the blister packet into the medication cup. ULP-A explained the medications to R1, R1 consumed the medication, and requested their inhaler. ULP-A provided R1 with the Advair inhaler and R1 administered the inhaler. ULP-A threw away the medication blister packet into the garbage can and placed the inhaler back in the medication cabinet, removed their gloves, and washed their hands. ULP-A applied a new pair of gloves, removed R2's morning blister packet from the medication closet, dumped the blister packed into the medication cup, explained the medications to R2, and R2 consumed the medications. ULP-A threw away the blister packet, locked the medication cabinet, removed their gloves, and sanitized their hands. ULP-A walked to the computer and clicked on the following boxes: set up, verify, administration, and then complete on the EMAR in RTasks for R2 and R1's morning medications listed above on the Med Admin	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36081	A. BUILDING: _____ B. WING _____	06/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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02320	Continued From page 41 Summary. ULP-A stated there were trained to administer medication by the five rights which included right route, right time, right patient, right number of medications, and documentation. The surveyor inquired how ULP-A verified the medication. ULP-A stated they verified the number of medications the residents received. The surveyor inquired how they completed this when they did not look at the electronic medication administration record (EMAR). ULP-A stated, "since I am here, I memorize it and check what I have." ULP-A stated when they arrived at the facility, they looked at the EMAR to see if there have been any changes in medication. ULP-A stated the pharmacy and nurse were "really good" at letting us know if there were any changes to medications. The licensee's Medication Administration policy dated July 11, 2022, indicated residents were entitled to safe administration of medication by qualified personnel according to a written medication management plan. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		

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

Type: Full
Date: *06/24/24*
Time: 13:46:49
Report: 8058241152

Food and Beverage Establishment Inspection Report

Location:
H And S Residence Llc
532 79th Avenue North
Brooklyn Park, MN55444
Hennepin County, 27

Establishment Info:
ID #: 0037792
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7633062336
ID #:

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

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

Hot Water: = at 160 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: TOMATO
Temperature: 41 Degrees Fahrenheit - Location: COOLER
Violation Issued: No

Process/Item: HOT DOG
Temperature: 41 Degrees Fahrenheit - Location: COOLER
Violation Issued: No

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

HRD INSPECTOR ASHLEY CREWS
ESTABLISHMENT REP KHADRO ABDI

RESIDENTIAL KITCHEN WITH NON COMMERCIAL APPLIANCES AND FINISHES

Type: Full
Date: *06/24/24*
Time: 13:46:49
Report: 8058241152
H And S Residence 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 8058241152 of 06/24/24.

Certified Food Protection Manager: SAHRA MUHUMED

Certification Number: 119644 Expires: 07/19/26

Inspection report reviewed with person in charge and emailed.

Signed: _____
Establishment Representative

Signed: _____
Aaron Gertz
Sanitarian 3
MDH Metro Office
651 201 4500
health.foodlodging@state.mn.us