



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

July 16, 2024

Licensee
Loving Homes Inc
3428 Lee Avenue North
Crystal, MN 55422

RE: Project Number(s) SL36446015

Dear Licensee:

On July 2, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the February 7, 2024, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in blue ink, appearing to read 'Jess Schoenecker'.

Jess Schoenecker, Supervisor
State Evaluation Team
Email: Jess.Schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 1-866-890-9290

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Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

May 16, 2024

Licensee
Loving Homes, Inc.
3428 Lee Avenue North
Crystal, MN 55422

RE: Project Number(s) SL36446015

Dear Licensee:

On April 25, 2024, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on February 7, 2024. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the February 7, 2024 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on February 7, 2024, found not corrected at the time of the April 25, 2024, follow-up survey and/or subject to penalty assessment are as follows:

0810-Fire Protection And Physical Environment-144g.45 Subd. 2 (b)-(f) - \$500.00

The details of the violations noted at the time of this follow-up survey completed on April 25, 2024 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

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

DOCUMENTATION OF ACTION TO COMPLY

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

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.

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.

We urge you to review these orders carefully. If you have questions, please contact Jessie Chenze at 218-332-5175 .

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

Sincerely,

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

Jessie Chenze, Supervisor
State Evaluation Team
Email: jessie@chenze@state.mn.us
Telephone: 218-332-5175 Fax: 1-866-890-9290

PMB

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36446	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 04/25/2024
NAME OF PROVIDER OR SUPPLIER LOVING HOMES INC		STREET ADDRESS, CITY, STATE, ZIP CODE 3428 LEE AVENUE NORTH CRYSTAL, MN 55422			
(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: SL36446015-1 On April 24, 2024, through April 25, 2024, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on February 7, 2024. At the time of the survey, there were 4 residents; all receiving services under the Assisted Living license. As a result of the revisit, the following orders were reissued.	{0 000}	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.		
{0 250} SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a	{0 250}			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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{0 250}	Continued From page 1 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 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	{0 250}			

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{0 250}	Continued From page 2 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: No further action required.	{0 250}			
{0 480} SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: No further action required.	{0 480}			
{0 550} SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances.	{0 550}			

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{0 550}	Continued From page 3 The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: No further action required.	{0 550}			
{0 640} SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: No further action required.	{0 640}			

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{0 660}	Continued From page 4	{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: No further action required.	{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;	{0 680}			

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{0 680}	Continued From page 5 and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: No further action required.	{0 680}			
{0 690} SS=F	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: No further action required.	{0 690}			
{0 730} SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of	{0 730}			

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{0 730}	Continued From page 6 the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or	{0 730}			

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{0 730}	Continued From page 7 status. This MN Requirement is not met as evidenced by: No further action required.	{0 730}			
{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	{0 810}			

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{0 810}	Continued From page 8 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 the required content. 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 April 25, 2024 at 2:00 p.m. survey staff emailed unlicensed personnel (ULP)-F requesting their updated fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. On April 26, 2024, at 2:00 p.m. ULP-F provided the requested documents. FIRE SAFETY AND EVACUATION PLAN The licensee's FSEP, titled "Fire", undated, 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	{0 810}			

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{0 810}	Continued From page 9 similar emergency relative to the facility's building layout and environmental risks. General instructions for evacuation were included, but the policy did not include clear directions to staff how to evacuate the building. 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 including individualized unique needs of residents. The plan included instructions to evacuate residents but did not include any procedures for assisting residents during evacuation nor did it include instructions for staff to follow in case of relocation. Survey staff email ULP-F on April 26, 2024 at 2:26 p.m. inquiring if there was any reason they were unable to update their policy since the time of the initial survey. On April 27, 2024, at 2:30 p.m. ULP-F emailed survey staff explaining that they took out the R.A.C.E. and P.A.S.S. acroynmys, but they were unclear on what needed to be changed. No further information was provided.	{0 810}			
{0 820} SS=E	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including	{0 820}			

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{0 820}	Continued From page 10 assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to ensure physical facility elements did not constitute a distinct hazard to life. The licensee failed to provide resident bedrooms with the minimum window opening meeting the minimum state standard for egress. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On April 24, 2024, at 11:30 a.m., survey staff toured the facility with unlicensed personnel (ULP)-B. During the tour, survey staff asked ULP-B if they had replaced any of the windows in	{0 820}			

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{0 820}	Continued From page 11 bedrooms #1 and #2. ULP-B stated they had not replaced any windows yet. The noncompliant measurements remain as follows: Occupied Sleeping Rooms: Bedroom #1 (R4): two windows measuring 28.5 inches clear width, 20.5 inches clear height, and 584.25 square inches total open area per window. Bedroom #2 (R3): two windows measuring 28.5 inches clear width, 20.5 inches clear height, and 584.25 square inches total open area per window. The windows in bedrooms #1 and #2 did not meet the minimum requirements for total open area. Egress windows in existing sleeping rooms must have a minimum openable width of 20 inches and minimum openable height of 20 inches with no less than 648 square inches total of openable area (4.5 square feet) for the window. Record review of the fire watch log indicated that the facility had an active fire watch and was completing it per their approved plan of correction. During interview on April 24, 2024, at 12:30 p.m. ULP-B explained that they had ordered windows through a window supplier, but the supplier had confused their facility with another facility of a similar name so the windows were never ordered. ULP-B stated they received verification from the supplier that the new windows had been ordered, and there was a verbal agreement that the new windows would be installed on May 6, 2024. ULP-B could not provide documentation of the window order confirmation. Record review of the written agreement with the	{0 820}			

Minnesota Department of Health

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{0 820}	Continued From page 12 window contractor did not include any information on the size of the window or the installation date. The information in the agreement included the contractor's business name and address, job description, number and cost of windows, labor costs, permit costs, and payment structure. No further information was provided.	{0 820}			
{0 910} SS=C	144G.50 Subd. 2 (a-b) Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name and the health facility identification of the facility. (b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility. This MN Requirement is not met as evidenced by: No further action required.	{0 910}			
{0 930} SS=C	144G.50 Subd. 2 (d-e; 1-4) Contract information (d) The contract must include a description of the facility's complaint resolution process available to residents, including the name and contact information of the person representing the facility who is designated to handle and resolve complaints. (e) The contract must include a clear and conspicuous notice of:	{0 930}			

Minnesota Department of Health

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{0 930}	Continued From page 13 (1) the right under section 144G.54 to appeal the termination of an assisted living contract; (2) the facility's policy regarding transfer of residents within the facility, under what circumstances a transfer may occur, and the circumstances under which resident consent is required for a transfer; (3) contact information for the Office of Ombudsman for Long-Term Care, the Ombudsman for Mental Health and Developmental Disabilities, and the Office of Health Facility Complaints; (4) the resident's right to obtain services from an unaffiliated service provider; This MN Requirement is not met as evidenced by: No further action required.	{0 930}			
{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: No further action required.	{0 970}			
{01620} SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must	{01620}			

Minnesota Department of Health

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{01620}	Continued From page 14 be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: No further action required.	{01620}			
{01650} SS=D	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring	{01650}			

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{01650}	Continued From page 15 assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: No further action required.	{01650}			
{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	{01750}			

Minnesota Department of Health

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{01750}	Continued From page 16 about the individual needs of the resident. This MN Requirement is not met as evidenced by: No further action required.	{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: No further action required.	{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	{01790}			

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{01790}	Continued From page 17 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 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	{01790}			

Minnesota Department of Health

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{01790}	Continued From page 18 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 doses of each returned medication. This MN Requirement is not met as evidenced by: No further action required.	{01790}			
{01830} SS=F	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: No further action required.	{01830}			
{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:	{01890}			

Minnesota Department of Health

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{01890}	Continued From page 19 No further action required.	{01890}			
{01910} SS=D	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 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: No further action required.	{01910}			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

February 16, 2024

Licensee
Loving Homes Inc
3428 Lee Avenue North
Crystal, MN 55422

RE: Project Number(s) SL36446015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on February 7, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement.

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

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

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

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5), MDH may impose fine amounts of either \$1,000 or \$5,000 to licensees who are found to be responsible for maltreatment. MDH may impose a fine of \$1,000 for each substantiated maltreatment violation that consists of

abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. MDH also may impose a fine of \$5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

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

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

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

St - 0 - 0830 - 144g.45 Subd. 3 - Local Laws Apply - \$3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$6,000.00** 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.

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

If you have any questions, please contact me.

Sincerely,

A handwritten signature in cursive script that reads "Jessica Chenze".

Jessie Chenze, Supervisor
State Evaluation Team
Email: jessie.chenze@state.mn.us
Telephone: 218-332-5175 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36446	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/07/2024
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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: SL36446015 On February 5, 2024, through February 7, 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 3 residents; all of whom were receiving services under the Assisted Living license. An immediate correction order was identified on February 6, 2024, issued for SL36446015-0, tag identification 0830. On February 8, 2024, the immediacy of correction order 0830 was removed, however, noncompliance remained at a scope and level of I. An immediate correction order was identified on February 5, 2024, issued for SL36446015-0, tag identification 0820.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.		

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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0 000	Continued From page 1	0 000			
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 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	0 250			

Minnesota Department of Health

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0 250	Continued From page 2 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 interview and record review, the licensee failed to show they met the requirements of licensure, by attesting the managerial officials who oversaw the day-to-day operations understood applicable statutes and rules; nor developed and/or implemented current policies and procedures as required. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and	0 250			

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0 250	Continued From page 3 is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on February 5, 2024, at 10:15 a.m., registered nurse (RN)-A and unlicensed personnel (ULP)-B stated the licensee's employees in charge of the facility were familiar with the assisted living regulations and the licensee provided medication and treatment management services. The licensee's "Application for Assisted Living License", section titled "Official Verification of Owner or Authorized Agent", (page 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 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 (opens in a new window). - Reporting of Maltreatment of Vulnerable Adults	0 250			

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0 250	Continued From page 4 (opens in a new window). - Electronic Monitoring in Certain Facilities (opens in a new window)." - I understand pursuant to Minn. Stat. sect. 13.04 Rights of Subjects of Data (opens in a new window), the Commissioner will use information provided in this application, which may include an in-person or telephone conference, to determine if the applicant meets the requirements for assisted living licensing. I understand I am not legally required to supply the requested information; however, failure to provide information or the submission of false or misleading information may delay the processing of my application or may be grounds for denying a license. I understand that information submitted to the commissioner in the application may, in some circumstances, be disclosed to the appropriate state, federal or local agency, and law enforcement office to enhance investigative or enforcement efforts or further a public health protective process. Types of offices include Adult Protective Services, offices of the ombudsmen, health-licensing boards, Department of Human Services, county or city attorneys' offices, police, local or county public health offices. - I understand in accordance with Minn. Stat. sect. 144.051 Data Relating to Licensed and Registered Persons (opens in a new window), all data submitted on this application shall be classified as public information upon issuance of a provisional license. All data submitted are considered private until MDH issues a license. - I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G (opens in a new window), and Minnesota Rules, chapter 4659 (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	0 250			

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0 250	Continued From page 5 operation of the facility, regardless of the existence of a management agreement or subcontract. - I have examined this application and all attachments and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct and complete. I will notify MDH, in writing, of any changes to this information as required. - I attest to have all required policies and procedures of Minn. Stat. chapter 144G (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 6 was electronically signed by the licensee on February 1, 2023. The licensee had an Assisted Living license, issued on April 1, 2023. The licensee failed to ensure the following policies and procedures were developed and/or implemented: - conducting initial and ongoing resident evaluations and assessments of resident needs; - conducting appropriate screenings, or documentation of prior screenings, to show that staff were free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention of Standards; and - medication management. As a result of this survey, the following orders were issued under 0660, 1620, 1750, 1760, 1790, 1830, 1890, and 1910, indicating the licensee's understanding of the Minnesota statutes were	0 250			

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0 250	Continued From page 6 limited, or not evident for compliance with the Minnesota statutes, section 144G.08 to 144G.95. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 250			
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 February 5, 2024, for the specific Minnesota Food Code violations. The Inspection	0 480			

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0 480	Continued From page 7 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			
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post in a conspicuous place, the contact information for the Office of Ombudsman for Long-Term Care (OOLTC) and the Office of Ombudsman for Mental Health and Developmental Disabilities (OOMHDD). This had the potential to affect the licensee's current residents, staff, and visitors. This practice resulted in a level two violation (a	0 550			

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0 550	Continued From page 8 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 February 5, 2024, at 11:00 a.m., the surveyor toured the common areas of the facility while staff was with a resident. The surveyor observed a bulletin board inside the main entrance and outside the office on the lower level, but was unable to locate the above required contact information. On February 5, 2024, at 11:22 a.m., unlicensed personnel (ULP)-B stated the grievance form posted did not have the required content, and stated it must have been left off when it was changed. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 550			
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by	0 640			

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0 640	Continued From page 9 the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to support protection and safety by not posting information and phone numbers for reporting to the Minnesota Adult Abuse Reporting Center (MAARC) in common areas as required. This had the potential to affect all current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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 February 5, 2024, at 11:00 a.m., the surveyor toured the common areas of the facility while staff was with a resident. The surveyor observed a bulletin board inside the main entrance and outside the office on the lower level, but was unable to locate the above required information. On February 5, 2024, at 11:22 a.m., unlicensed personnel (ULP)-B stated the posting information for MAARC was not available, and must have	0 640			

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0 640	Continued From page 10 been removed when the postings were updated. The licensee's Vulnerable Adult policy dated August 1, 2021, noted "Contact information for the MAARC shall be posted in the facility." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 640			
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 observation, 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) including completion of a current facility	0 660			

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0 660	Continued From page 11 risk assessment, documentation of a completed health history and symptom screening for one of two employees (registered nurse/RN-A), and evidence of a two-step tuberculin skin test (TST) or other evidence of TB screening such as a blood test for one of two employees (RN-A). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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: Facility Risk Assessment During the entrance conference on February 5, 2024, at 10:15 a.m., the surveyor requested to review the licensee's current facility risk assessment. Unlicensed personnel (ULP)-B provided a binder with multiple risk assessments, with the most current dated August 1, 2022, and the risk level noted as N/A (not applicable). ULP-B stated he would look to see if the director had a current version. However, none was provided. RN-A RN-A was hired on January 12, 2024, to provide direct care and services to the licensee's residents and oversight of the licensee's employees. On February 6, 2024, at approximately 2:40 p.m., RN-A was observed on the main floor, interacting with the licensee's residents.	0 660			

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0 660	Continued From page 12 RN-A's employee record contained a Quantiferon TB Gold Plus dated December 4, 2020, (greater than 90 days prior to hire). In addition, RN-A's record lacked evidence of a completed TB history and symptom screening. On February 6, 2024, at 1:00 p.m., RN-A stated she was the nurse hired recently to cover for the main nurse, and she thought the history and screening had been completed and would check for it. However, no information was provided. The licensee's Tuberculosis Screening/Prevention policy dated August 1, 2021, noted the director was responsible for conducting the formal TB risk assessment annually. It also noted it would identify the risk classification as low, medium, or potential ongoing transmission. The policy noted the licensee had no residents with TB and was classified as low risk. It noted staff screening would include an individual risk assessment and symptom evaluation and TST or blood test. 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 infection control program should include a facility TB risk assessment. The guidelines also indicated an employee may begin working with patients after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW (health care worker) starts working with patients. Baseline TB screening should be documented in the employee's record.	0 660			

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0 660	Continued From page 13 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660			
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to have a written	0 680			

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0 680	Continued From page 14 emergency preparedness plan (EPP) with all the required content defined in Appendix Z. In addition, the licensee failed to evaluate the missing resident plan at least quarterly. This had the potential to affect all current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During a facility tour with unlicensed personnel (ULP)-B on February 5, 2024, at 1:15 p.m., they surveyor observed the facility's layout including the upper level with three bedrooms, a living and dining area, kitchen, and bathroom. The lower level included one bedroom, two offices, a living area, bathroom, and utility room. The licensee's Emergency Preparedness Manual included an EPP Annual Review sheet, with dates of review as August 1, 2021, August 1, 2022, and August 1, 2023. It included a Hazard Vulnerability Assessment dated September 2023. The EPP lacked the following required content: - documentation of a missing resident plan that was reviewed quarterly; - process for cooperation and collaboration with local, tribal, regional, State, and Federal EP to maintain integrated response; - alternate sources of energy to maintain temperatures to protect resident health/safety, fire	0 680			

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0 680	Continued From page 15 detection, extinguishing, alarm systems, and sewage and waste disposal; - policy/procedure to address a system of medical documentation that preserves resident information, protects confidentiality, and secures/maintains availability of records; - policy/procedure to address the use of volunteers, including the process/role for integration; - a communication plan that included: - names/contact information of staff, entities providing services under the agreement, residents' physicians, other facilities, volunteers, Federal, State, tribal, regional EP staff, State Licensing and Certification Agency, and MN Office of Ombudsman; - contact information for Federal, State, tribal, regional local EP staff, State Licensing and Certification Agency, Minnesota (MN) Office of Ombudsman for Long Term Care, and other sources of assistance; - means to providing information about the facility's occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee; and - training program to include initial training to all new and existing staff, individuals providing services under arrangement, and volunteers consistent with their expected role, and annual training. On February 7, 2024, at 2:50 p.m., ULP-B stated the missing resident plan was reviewed annually with the EPP, but was not aware of the requirement to review quarterly. In addition, ULP-B stated they have processes in place, but not the required policies. Per Assisted Living Facilities: Minnesota Rules	0 680			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 680	Continued From page 16 Chapter 4695, 4659.0100, sections A and B, assisted living facilities shall comply with the federal emergency preparedness regulations for long-term care facilities under Code of Federal Regulations, title 42, section 483.73, or successor requirements. This part references documents, specifications, methods, and standards in "State Operations Manual Appendix Z - Emergency Preparedness for All Providers and Certified Supplier Types: Interpretive Guidance," which is incorporated by reference. Per Assisted Living Facilities: Minnesota Rules Chapter 4659, 4659.0110, Subp. 4. Review missing resident plan. The assisted living director and clinical nurse supervisor must review the missing person plan at least quarterly and document any changes to the plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680			
0 690 SS=F	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 ensure resident assessments were authenticated with the name and title of the person who completed the assessment and failed	0 690			

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0 690	Continued From page 17 to ensure the assessment included the date the assessments were completed for three of three residents (R1, R3, R4). 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: R1 R1's record contained a Resident Evaluation, which was not authenticated with the name and title of the person who completed the assessment and lacked the date the assessment was completed. R1's diagnoses included hypertension and arthritis. R1's record contained an Assisted Living Contract dated August 1, 2023. R1's Service Plan dated August 1, 2023, noted services including medication administration, blood glucose monitoring, and daily blood pressure. R3 R3's record contained a Resident Evaluation, which was not authenticated with the name and title of the person who completed the assessment and lacked the date the assessment was completed.	0 690			

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0 690	Continued From page 18 R3's diagnoses included chronic obstructive pulmonary disease (COPD). R3's Service Plan dated October 18, 2022, noted services including medication administration and assistance with meals. R3's record contained an Assisted Living Contract dated October 18, 2023. R4 R4's record contained a Resident Evaluation, which was not authenticated with the name and title of the person who completed the assessment and lacked the date the assessment was completed. R4's diagnoses included schizoaffective disorder. R4's record contained an Assisted Living Contract dated March 29, 2023. R4's Service Plan dated March 29, 2023, noted services including reminders with grooming and dressing, and medication administration. On February 6, 2024, at 10:55 a.m., unlicensed personnel (ULP)-B stated this assessment form was utilized for the annual assessment and was typically completed at the same time as the contract was signed. ULP-B said the assessments lacked a spot to include the name and title of the person completing the assessment and the date of the assessment. The licensee's Clinical Records policy dated August 1, 2021, noted all entries would be legible, permanently recorded in ink, dated, and authenticated with the name and title of the	0 690			

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0 690	Continued From page 19 person making the entry. The licensee's Assessments, Reviews & Monitoring policy dated August 1, 2021, indicated the initial nursing assessment or reassessment must include all the elements of the uniform assessment tool as required, conducted in person (unless see #2), be in writing, dated, and signed by the registered nurse who conducted the assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 690			
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous	0 730			

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0 730	Continued From page 20 assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident record included a discharge summary with the required content for one of one discharged resident (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	0 730			

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0 730	Continued From page 21 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 admitted to the facility on May 22, 2023, and discharged on January 1, 2024. R2's diagnoses included schizophrenia. R2's care plan dated May 22, 2023, noted services including assistance with hygiene and grooming and medication administration. R2's Discharge Summary dated January 1, 2023 (noted by unlicensed personnel (ULP)-B as incorrect date on interview), noted client was alert and oriented times four, and denied pain at the time of discharge. The discharge summary, completed by clinical nurse supervisor (CNS)-E, noted the reason for discharge was that resident had found an apartment. However, the discharge summary lacked a summary of the resident's stay including: - courses of illnesses; - allergies; - treatments and therapies; - pertinent lab, radiology, and consultation reports; and - a final summary of the resident's status from the latest assessment or review including baseline and current mental, behavioral, and functional status. On February 6, 2024, at 2:25 p.m., registered nurse (RN)-A stated she was familiar with the required content of the discharge summary and would expect all content to be included. RN-A stated R2's discharge summary did not include the required content.	0 730			

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0 730	Continued From page 22 The licensee's Discharge and Transfer of Residents policy dated August 1, 2021, noted the discharge summary would include a summary of the resident's stay including diagnoses, courses of illnesses, allergies, treatments, therapies, pertinent lab, radiology and consultation reports, and a final summary of the resident's status from the last assessment or review, including baseline and current mental, behavioral and functional status. Minnesota Rules Chapter 4659.0120 Subp. 9, noted at the time of discharge, the facility must provide the resident, and with the resident's consent, the resident's representatives and case manager, with a written discharge summary including a summary of the resident's stat that includes diagnoses, course of illnesses, allergies, treatments and therapies, and pertinent lab, radiology, and consultation results, and a final summary of the resident's status from the latest assessment or review under Minnesota Statutes, section 144G.70, if applicable, that includes the resident's status, including baseline and current mental, behavioral, and functional status. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 730			
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and:	0 780			

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0 780	Continued From page 23 (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that functioned and are interconnected so that the actuation of one alarm causes all alarms in the dwelling unit to actuate. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	0 780			

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0 780	Continued From page 24 Findings include: On February 5, 2024, at 10:30 a.m., survey staff toured the facility with unlicensed personnel (ULP)-B. Survey staff tested the smoke alarms throughout the home. Upon testing, it was found that the smoke alarms in the facility were not all interconnected and the smoke alarm in the main-level living room did not work. These deficient conditions were visually verified by ULP-B accompanying on the tour. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780			
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.	0 810			

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0 810	Continued From page 25 (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 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, 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 February 7, 2024, unlicensed personnel (ULP)-B provided documents on the fire safety and evacuation plan (FSEP), fire safety and	0 810			

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0 810	Continued From page 26 evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The licensee's FSEP, titled "Fire Emergency", undated, 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) and P.A.S.S. (Pull, Aim, Squeeze, Sweep) but the plan was designed for a building with life safety systems such as fire doors and smoke compartments. 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 have life safety systems or a fire-resistant construction type. 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 including individualized unique needs of residents. The plan included instructions to evacuate residents but did not include any procedures for assisting residents during evacuation nor did it include instructions for staff to follow in case of relocation.	0 810			

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0 810	Continued From page 27 During an interview on February 7, 2024, at 2:00 p.m., ULP-B stated they had not had an opportunity to update the policy to make it site specific. The policy reviewed was an unedited policy purchased from a third-party provider that was not specific to the facility. TRAINING Record review indicated the licensee failed to provide evacuation training to residents at least once per year. ULP-B was unable to provide documentation showing any training offered or training scheduled for a future date for residents on the fire safety and evacuation plan. Record review indicated the licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. ULP-B was unable to provide documentation showing any training provided or training scheduled for a future date for staff on the fire safety and evacuation plan. During an interview on February 7, 2024, at 2:00 p.m., ULP-B stated he had not completed the required trainings. DRILLS 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. Provided documentation indicated that drills were completed on 12/20/2023. During an interview on February 7, 2024, at 2:00 p.m., ULP-B confirmed there were no additional evacuation drills completed at the facility and acknowledged the deficient conditions	0 810			

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0 810	Continued From page 28	0 810			
0 820 SS=I	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure physical facility elements did not constitute a distinct hazard to life. The licensee failed to provide resident bedrooms with the minimum window opening meeting the minimum state standard for egress. This had the potential to affect all residents, staff, 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	0 820	This immediate correction order identified on February 5, 2024, has had the immediacy lifted as of February 12, 2024, however non-compliance remained a scope and level of I.		

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0 820	Continued From page 29 portion or all of the residents). The findings include: On February 05, 2024, at 10:30 a.m., survey staff toured the facility with unlicensed personnel (ULP)-B. During the tour, survey staff asked ULP-B to open the windows in resident bedrooms #1 - #4 for measurement. The measurements were as follows: Occupied Sleeping Rooms: Bedroom #1 (R4): two windows measuring 28.5 inches clear width, 20.5 inches clear height, and 584.25 square inches total open area per window. Bedroom #2 (R3): two windows measuring 28.5 inches clear width, 20.5 inches clear height, and 584.25 square inches total open area per window. The windows in bedrooms #1, #2 did not meet the minimum requirements for total open area. Survey staff explained to ULP-B that at least one window in each bedroom in a state-licensed facility must meet the minimum state fire code standard for an egress window to be a complying bedroom for resident occupancy. Egress windows in existing sleeping rooms must have a minimum openable width of 20 inches and minimum openable height of 20 inches with no less than 648 square inches total of openable area (4.5 square feet) for the window. On February 07, 2024, at 11:00 a.m., at the exit interview, survey staff explained to ULP-B that an immediate correction order was issued for the above finding. ULP-B acknowledged the above finding. No Further information was provided.	0 820			

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0 820	Continued From page 30	0 820			
0 830 SS=I	144G.45 Subd. 3 Local laws apply Assisted living facilities shall comply with all applicable state and local governing laws, regulations, standards, ordinances, and codes for fire safety, building, and zoning requirements. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to follow applicable state and local laws, regulations, standards, ordinances, and codes related to smoking for three of three residents (R1, R3, R4). This resulted in an immediate correction order on February 6, 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 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 February 5, 2024, at 10:00 a.m., when arriving at the home, the surveyor observed two partially smoked cigarettes, neither of which were lit at that time, on top of the wooden deck rail, approximately 6 inches from the side of the house.	0 830			

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NAME OF PROVIDER OR SUPPLIER LOVING HOMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 3428 LEE AVENUE NORTH CRYSTAL, MN 55422		
(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
0 830	Continued From page 31 During a facility tour with unlicensed personnel (ULP)-B on February 5, 2024, at 1:15 p.m., the outside of the facility was observed. ULP-B said residents do smoke here, and when asked where they extinguished the cigarettes, he was unable to locate an ashtray in the front of the house. ULP-B stated residents smoke out back, and opened the garage door. The garage was very packed with a vehicle, and items such as empty boxes and wrapping paper on top of the vehicle. There was a work bench against the wall, with miscellaneous craft items on it, including a spray can of Rustoleum gloss and two bottles of glue. A space heater was observed on the floor of the garage, plugged into a surge protector, that was plugged into an extension cord. There was an approximately 3 foot path to go in the garage between the bench and the chairs and tables, which are placed with the backs to the side of the parked vehicle. There were two open style ashtrays and one closed style ashtray, with cigarettes in each ashtray. On February 6, 2024, at 9:30 a.m., the surveyor asked R3 where they smoke. She said she would show me, and grabbed her cigarettes and went outside to the garage. R3 was observed to light up, smoke her cigarette, and extinguish it in the ashtray. The garage had a strong odor of cigarette smoke. R3 said they smoke in the garage since it is warmer than outside. She said they use the space heater and turn it off when they go inside. However, she did not turn the heater on at this time. R3 stated they had placed a blanket on the inside of the garage door to prevent drafts coming in. A green blanket was observed covering the inside of the door. R3 stated staff sometimes come outside with her, but they don't smoke so it doesn't happen very often.	0 830			

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0 830	Continued From page 32 R3 stated the nurse has not watched her smoke. On February 6, 2024, at 10:30 a.m., the surveyor observed R4 outside with a lit cigarette. R4 was standing on the top step, and was smoking. The wooden deck was attached to the stairs, and R4 stated when he finished his cigarette, he flicked the cherry off and threw the butt away inside the house. When he finished his cigarette, he knocked the cherry off, which landed on the top of the wooden deck, and went inside. At this time, the surveyor brought ULP-D outside. She had been seated at the table just inside the front door. The surveyor informed ULP-D the cherry from the cigarette had been dropped on the board, and ULP-D extinguished it with her shoe. At this time, ULP-D stated R4 is not supposed to smoke in front, but forgets and needs a lot of reminders to smoke in back, and thought he was just outside for fresh air, not smoking at this time. ULP-D said residents are supposed to smoke in the garage. In addition, ULP-D stated the nurse does talk with residents about how to smoke safely and watches them smoke. On February 6, 2024, at 11:38 a.m., R1 was observed in the garage, sitting on a chair in front of the space heater with a lit cigarette. R1 said he turned the space heater on when he came to the garage, and will turn it off when he is done. R1 said this is where he smokes, protected form the cold. When finished, R1 was observed to extinguish the cigarette in the ashtray, turn off the heater and lights, and exit the garage. On February 6, 2024, at 12:00 p.m., ULP-B stated R4 requires many prompts to go out back and smoke. ULP-B said residents are supposed to smoke in the back on the concrete by the table, but they keep bringing their chairs and ashtrays	0 830			

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0 830	Continued From page 33 into the garage and smoke there. ULP-B said he is aware there is a space heater in the garage that residents use while smoking. On February 6, 2024, at 1:15 p.m., registered nurse (RN)-A stated she would complete a smoking assessment if she observed the client smoking unsafely or if staff notified her of any new concerns. RN-A states she would expect staff to notify her if there were any changes with the smoking behaviors or if residents were smoking unsafely. RN-A stated she has only seen residents smoking in the designated area. At this time, RN-A and ULP-B stated there are no smoke detectors or fire extinguishers in the garage. In addition, ULP-B stated he was aware residents were smoking in the garage. ULP-B stated smoking behavior and prompts are documented in the electronic record, and he will provide copies of this. ULP-B stated R4 did not have this issues of smoking in front before, but had changed about four months ago. ULP-B stated clinical nurse supervisor (CNS)-E was made aware of this. R1 R1 admitted to the facility on December 30, 2020. R1's diagnoses included hypertension and arthritis. R1's undated Resident Evaluation (identified as the annual assessment, completed at the time the contract is signed by ULP-B), noted R1 was a smoker, and under "Safety Factors with Smoking" was noted "NO". R1's record contained an Assisted Living Contract dated August 1, 2023.	0 830			

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0 830	Continued From page 34 R1's Service Plan dated August 1, 2023, noted services including medication administration, blood glucose monitoring, and daily blood pressure. R3 R3 admitted to the facility on October 18, 2022. R3's diagnoses included chronic obstructive pulmonary disease (COPD). R3's undated Resident Evaluation noted R3 was a smoker, and under "Safety Factors with Smoking" was noted "none". R3's Service Plan dated October 18, 2022, noted services including medication administration and assistance with meals. R3's record contained an Assisted Living Contract dated October 18, 2023. R4 R4 admitted to the facility on March 29, 2022. R4's diagnoses included schizoaffective disorder. R4's undated Resident Evaluation noted R4 was a smoker, and under "Safety Factors with Smoking" was noted "NO". R4's record contained an Assisted Living Contract dated March 29, 2023. R4's Service Plan dated March 29, 2023, noted services including reminders with grooming and dressing, and medication administration. The Minnesota Department of Health's Minnesota Clean Indoor Air Act (MCIAA) amendment	0 830			

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0 830	Continued From page 35 effective on August 1, 2019, noted smoking was prohibited in health care facilities and clinics. In addition, an indoor area meant a space between a floor and a ceiling that is at least half enclosed by walls, doorways or windows (opened or closed) around the perimeter. A wall included retractable dividers, garage doors, plastic sheeting or any other temporary or permanent physical barrier. Minnesota State Statute 144.414 Prohibitions; Subdivision 3 dated 2022, indicated under a section titled Health care facilities and clinics: (a) Smoking is prohibited in any area of a hospital, health care clinic, doctor's office, licensed residential facility for children, or other health care-related facility, except that a patient or resident in a nursing home, boarding care facility, or licensed residential facility for adults may smoke in a designated separate, enclosed room maintained in accordance with applicable state and federal laws. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE Immediacy was removed based on supervisor review of action plan on February 7, 2024, however non-compliance remains at a scope and level of level three, widespread (I).	0 830			
0 910 SS=C	144G.50 Subd. 2 (a-b) Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name and the health facility identification of the facility. (b) The contract must include the name, telephone number, and physical mailing address,	0 910			

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0 910	Continued From page 36 which may not be a public or private post office box, of: (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for three of three residents (R1, R3, R4). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 R1's Assisted Living Contract was signed by R1 on August 1, 2023. R1's contract did not include the provider's health facility identification (HFID) number. R3 R3's Assisted Living Contract was signed by R3 on October 18, 2023. R3's contract did not include the provider's HFID number.	0 910			

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0 910	Continued From page 37 R4 R4's Assisted Living Contract was signed by R4 on March 29, 2023. R4's contract did not include the provider's HFID number. On February 7, 2024, at 3:35 p.m., unlicensed personnel (ULP)-B stated he was not aware of the requirement to include the HFID number in the contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 910			
0 930 SS=C	144G.50 Subd. 2 (d-e; 1-4) Contract information (d) The contract must include a description of the facility's complaint resolution process available to residents, including the name and contact information of the person representing the facility who is designated to handle and resolve complaints. (e) The contract must include a clear and conspicuous notice of: (1) the right under section 144G.54 to appeal the termination of an assisted living contract; (2) the facility's policy regarding transfer of residents within the facility, under what circumstances a transfer may occur, and the circumstances under which resident consent is required for a transfer; (3) contact information for the Office of Ombudsman for Long-Term Care, the Ombudsman for Mental Health and Developmental Disabilities, and the Office of	0 930			

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0 930	Continued From page 38 Health Facility Complaints; (4) the resident's right to obtain services from an unaffiliated service provider; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for three of three residents (R1, R3, R4). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 R1's diagnoses included hypertension (high blood pressure) and arthritis. R1's Service Plan dated August 1, 2023, noted services including medication administration, blood glucose monitoring, and daily blood pressure. R1's Assisted Living Contract was signed by R1 on August 1, 2023. The contract noted on page 9, "Term and Termination: Refer also to Discharge and Transfer of Residents and the Nonrenewal of Housing, Service Reduction and Planned Closure policies". The contract did not include the facility's policy regarding transfer of residents within the facility, under what circumstances a transfer may occur, and the	0 930			

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0 930	Continued From page 39 circumstances under which resident consent is required for a transfer. R3 R3's diagnoses included chronic obstructive pulmonary disease (COPD). R3's Service Plan dated October 18, 2022, noted services including medication administration and assistance with meals. R3's Assisted Living Contract was signed by R3 on October 18, 2023. The contract noted on page 9, "Term and Termination: Refer also to Discharge and Transfer of Residents and the Nonrenewal of Housing, Service Reduction and Planned Closure policies". The contract did not include the facility's policy regarding transfer of residents within the facility, under what circumstances a transfer may occur, and the circumstances under which resident consent is required for a transfer. R4 R4's diagnoses included schizoaffective disorder. R4's Service Plan dated March 29, 2023, noted services including reminders with grooming and dressing, and medication administration. R4's Assisted Living Contract was signed by R4 on March 29, 2023. The contract noted on page 9, "Term and Termination: Refer also to Discharge and Transfer of Residents and the Nonrenewal of Housing, Service Reduction and Planned Closure policies". The contract did not include the facility's policy regarding transfer of residents within the facility, under what circumstances a transfer may occur, and the circumstances under which resident consent is	0 930			

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0 930	Continued From page 40 required for a transfer. On February 7, 2024, at 3:35 p.m., unlicensed personnel (ULP)-B stated although the contact referred to a transfer policy, this policy was not provided to residents that he was aware of. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 930			
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 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. This had the potential to affect all current residents. 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	0 970			

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0 970	Continued From page 41 or has the potential to affect a large portion or all the residents). The findings include: The Assisted Living Contract provided included the following clauses which indicated the resident would waive the facility's liability for health, safety, or personal property of the resident. Insurance Liability and Release, page 11 of the contract, "The resident shall maintain at all times his or her own health, personal property, liability, automobile (if applicable), and other insurance coverages and shall provide evidence of same by copies of binders or policies provided to Loving Homes upon request. The resident acknowledges that Loving Homes is not an insurer of the resident's person or property. The resident agrees that Loving Homes will 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 the injury or damage is caused by the negligence of Loving Homes or its employees or agents. The resident hereby releases Loving Homes from liability for any personal injury or property damage suffered by the resident or the resident's agents, guests, or invitees, unless caused by the negligence of Loving Homes or its employees or agents". Indemnification, page 13 of the contract, "Loving Homes shall not be liable for any damage or injury to the resident, or any other person, or to any property, occurring on the premises, or any part thereof, or in common areas thereof, and the resident agrees to hold Loving Homes harmless	0 970			

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0 970	Continued From page 42 from any claims or damages unless caused solely by negligence of Loving Homes. It is recommended that renter's insurance be purchased at the resident's expense. Nothing contained herein is intended to create a waiver of facility liability for the health and safety or personal property of a resident". Liability, page 13 of the contract, "The resident agrees to be liable and responsible for all obligations herein referenced, monetary and otherwise, of the resident and where this Contract has been executed by a party designated below. Or where a separate Responsible Party Agreement has been executed by a third party, said third party and the resident shall be jointly and severally liable and responsible for all obligations, monetary and otherwise, of the resident herein referenced". On February 7, 2024, at 3:35 p.m., unlicensed personnel (ULP)-B stated these clauses are included in the contract, and the same contract template is utilized for all residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 970			
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days	01620			

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01620	Continued From page 43 from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) completed a comprehensive reassessment using the uniform assessment tool for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1's diagnoses included hypertension and	01620			

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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
01620	Continued From page 44 arthritis. On February 6, 2024, at 11:47 a.m., the surveyor observed unlicensed personnel (ULP)-B provide reminders for R1 to perform a blood glucose check, and observed R1 perform the check. R1's Service Plan dated August 1, 2023, noted services including medication administration, blood glucose monitoring, and daily blood pressure. R1's record contained a Nurse Reassessment Visit form dated August 1, 2023, and November 24, 2023, (116 days after the last assessment). Both assessments were identified as a 90-day reassessment. The assessment contained an assessment of the vital signs, physical examination of the body systems, infectious disease, emotional/mental health, psychosocial/supports/cultural, communication, activity level, mobility, safety, falls, vulnerability, equipment, emergency services, appointments, and medication care plan. However, the assessment lacked all elements of the universal assessment tool. On February 6, 2024, at 12:40 p.m., RN-A stated the reassessment form is utilized for all residents, and lacks the full required content of the uniform assessment tool. In addition, RN-A stated assessments are to be completed at least every 90 days. ULP-B stated the same reassessment form was utilized for all residents. Minnesota Rules - Assisted Living Facilities 4659.0150 Uniform Assessment Tool, subdivision 2 indicated each facility must develop a uniform assessment tool. The facility may use an acceptable form or format for the tool, such as an	01620			

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01620	Continued From page 45 online or a hard-copy paper assessment tool, as long as the tool includes the elements identified in this subpart. The licensee's Assessment and Reassessment policy dated August 1, 2021, noted ongoing resident reassessments must be conducted by the RN and cannot exceed 90 days from the date of the last assessment. The licensee's Comprehensive Nursing Assessment policy dated August 1, 2021, noted the RN would conduct a comprehensive assessment utilizing a uniform assessment tool. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620			
01650 SS=D	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility;	01650			

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01650	Continued From page 46 (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a service plan included the required content for one of three residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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's diagnoses included hypertension and arthritis. On February 6, 2024, at 11:47 a.m., the surveyor observed unlicensed personnel (ULP)-B provide reminders for R1 to perform a blood glucose check, and observed R1 perform the check.	01650			

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01650	Continued From page 47 R1's Service Plan dated August 1, 2023, noted services including medication administration, blood glucose monitoring, and daily blood pressure. However, the service plan lacked - identification of and information as to who had authority to sign for the resident in an emergency. On February 6, 2024, at 12:40 p.m., ULP-B stated R1 did not want to have anyone sign for him, but noted the service plan did not identify this. The licensee's Service Plan policy dated August 1, 2021, noted the service plan would include the identification of an information as to who had the authority to sign for the resident in an emergency. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01650			
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	01750			

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01750	Continued From page 48 by: Based on observation, interview, and record review, the licensee failed to ensure as needed (PRN) medications included parameters for administration for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's record lacked specific written instructions regarding the administration of PRN medication ordered with a dosage range. R1's diagnoses included hypertension and arthritis. On February 6, 2024, at 11:47 a.m., the surveyor observed unlicensed personnel (ULP)-B provide reminders for R1 to perform a blood glucose check, and observed R1 perform the check. R1's Service Plan dated August 1, 2023, noted services including medication administration, blood glucose monitoring, and daily blood pressure. R1's prescriber orders dated September 22, 2022, included acetaminophen 500 milligram (mg) tablet, take 1-2 tablets by mouth every six hours as needed for moderate pain.	01750			

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01750	Continued From page 49 On February 6, 2024, at 12:40 p.m., registered nurse (RN)-A stated the order for acetaminophen is a range order and lacked indication on when to give one or two tablets. RN-A stated she was not aware of any concern with a range order. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	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 verify accuracy of prescriber orders when transcribing orders for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	01760			

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01760	Continued From page 50 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's diagnoses included hypertension and arthritis. On February 6, 2024, at 11:47 a.m., the surveyor observed unlicensed personnel (ULP)-B provide reminders for R1 to perform a blood glucose check, and observed R1 perform the check. R1's Service Plan dated August 1, 2023, noted services including medication administration, blood glucose monitoring, and daily blood pressure. R1's prescriber orders dated September 22, 2022, included atorvastatin (to treat high cholesterol) 20 milligram (mg) tabs, take one tablet by mouth daily. R1's February 2024 Medication Administration Record Data included the following: - atorvastatin 40 mg tablet, with instructions that noted to take one tablet (20 mg) by mouth daily. On February 6, 2024, at 12:40 p.m., registered nurse (RN)-A stated this appeared to be a transcription error. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760			

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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 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	01790			

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01790	Continued From page 52 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 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 comprehensive written procedures for the unlicensed personnel (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 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).	01790			

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01790	Continued From page 53 The findings include: During the entrance conference on February 5, 2024, at 10:15 a.m., registered nurse (RN)-A stated the licensee provided medication management services to the licensee's residents. The licensee's Medication Management Plan for Residents Away from Home policy dated August 1, 2021, indicated for unplanned times away from home when an adequate medication supply cannot be obtained from pharmacy or set up by the RN, the RN may delegate to an ULP if the RN had developed written procedures including the type of container(s) to be used, how the container(s) should be labeled, written information about the medications to be provided, documentation requirements including date the medications were provided, who received the medications, who provided the medications to the resident, and how the RN should be notified that the medications were given to the resident or designated representative. The untitled and undated sheet with written procedures provided lacked the following: - 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; - 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; and	01790			

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01790	Continued From page 54 - a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel. On February 7, 2024, at 12:30 p.m., ULP-B stated he thought there was an addendum to this list. However, no further information was provided. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790			
01830 SS=F	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 one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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).	01830			

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01830	Continued From page 55 The findings include: During the entrance conference on February 5, 2024, at 10:15 a.m., registered nurse (RN)-A and unlicensed personnel (ULP)-B stated the licensee provided medication management services to the residents at the facility. R1's diagnoses included hypertension and arthritis. On February 6, 2024, at 11:47 a.m., the surveyor observed ULP-B provide reminders for R1 to perform a blood glucose check, and observed R1 perform the check. R1's Service Plan dated August 1, 2023, noted services including medication administration, blood glucose monitoring, and daily blood pressure. R1's prescriber orders dated September 22, 2022, included one pain reliever, one anti-anxiety medication, and one antihypertensive medication (to lower blood pressure). R1's February 2024 Medication Administration Record Data listed medications as prescribed, times to administer, and staff initials to indicate the medications had been given. On February 6, 2024, at 1:04 p.m., ULP-B stated they had just recently found out they need to get annual orders for the resident's medications. ULP-B stated they did not have annual orders renewed for any of the residents. The licensee's Medication Orders policy dated August 1, 2021, noted medication orders would	01830			

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01830	Continued From page 56 be renewed at least every 12 months or as required by the physician, the RN assessment, or regulation. No further information. TIME PERIOD OF CORRECTION: Seven (7) days	01830			
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 a prescription label with legible information for one of three residents (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: During the entrance conference on February 5,	01890			

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01890	Continued From page 57 2024, at 10:15 a.m., registered nurse (RN)-A and unlicensed personnel (ULP)-B stated the licensee provided medication management services to the residents at the facility. On February 6, 2024, at 2:18 p.m., the surveyor completed a review of the licensee's medication storage in the presence of RN-A. R3's opened Trelegy Ellipta inhaler lacked a prescription label with the required information. R3's diagnoses included chronic obstructive pulmonary disease (COPD). R3's Service Plan dated October 18, 2022, noted services including medication administration and assistance with meals. R3's opened Trelegy Ellipta inhaler lacked a prescription label with the required information. On February 6, 2024, at 2:18 p.m., RN-A stated all medications should be stored with the original pharmacy label and the box may have been discarded by staff with the label on it. The licensee's Insulin policy dated July 26, 2021, instructed to compare the information on the administration record and the label, and stated both should contain the resident name, name of the medication, strength and dosage of the medication, the route, time that the medication is to be given, and any special instructions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890			

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01910	Continued From page 58	01910			
01910 SS=D	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 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's record, the disposition of the medications with the required content for one of one discharged resident (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	01910			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36446	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/07/2024
NAME OF PROVIDER OR SUPPLIER LOVING HOMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 3428 LEE AVENUE NORTH CRYSTAL, MN 55422		
(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
01910	Continued From page 59 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 admitted to the facility on May 22, 2023, and discharged on January 1, 2024. R2's diagnoses included schizophrenia. R2's care plan dated May 22, 2023, noted services including assistance with hygiene and grooming and medication administration. R2's Discharge Summary dated January 1, 2023 (noted by unlicensed personnel (ULP)-B as incorrect date on interview), noted medications at discharge included metformin and olanzapine. The section titled "Disposition of Medications (if applicable)" was left blank. On February 6, 2024, at 2:25 p.m., registered nurse (RN)-A stated she was familiar with the required content of the medication disposition, and added the form lacked the required content regarding the medications. The licensee's Disposition and Disposal of Medications policy dated August 1, 2021, noted upon disposition, the licensee would document the name, strength and prescription number of medication as applicable, quantity, method of disposition or to whom the medications were given, date of disposition, names and signatures of staff or other individuals involved in the disposition, and to whom the medications were given if applicable. No further information was provided.	01910			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36446	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/07/2024
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01910	Continued From page 60 TIME PERIOD FOR CORRECTION: Seven (7) days	01910			



Minnesota Department of Health

625 Robert Street North
St Paul
651-201-4500

Type: Full
Date: 02/05/24
Time: 11:53:10
Report: 7994241017

Food and Beverage Establishment Inspection Report

Page 1

Location:

Loving Homes Inc
3428 Lee Avenue North
Crystal, MN55422
Hennepin County, 27

Establishment Info:

ID #: 0037493
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7632854303
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.

4-300 Equipment Numbers and Capacities

4-302.13A **** Priority 2 ****

MN Rule 4626.0710A Provide a readily accessible temperature measuring device for measuring the washing and sanitizing temperatures in manual warewashing operations.

FACILITY DOES NOT CURRENTLY HAVE A WAY TO TEST DISHWASHER TEMPS. DISCUSSED VARIOUS WAYS WITH THE FACILITY.

Comply By: 02/05/24

5-200C Plumbing: Maintenance, fixture location

5-205.11AB **** Priority 2 ****

MN Rule 4626.1110AB The handwashing sink must be accessible at all times for employee use, and must be used only for handwashing.

HANDWASH SINK IS NOT DESIGNATED. ENSURE IT IS ONLY USED FOR HANDWASHING.

Comply By: 02/05/24

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

INSPECTION CONDUCTED IN THE PRESENCE OF HRD STAFF AND FINDINGS SHARED AT THE END OF INSPECTION.

WILL EMAIL SUPPORTING DOCUMENTS AND LINKS TO HRD STAFF AT THE END OF THE DAY.

KITCHEN IS RESIDENTIAL AND FOOD IS PREPARED FOR SAME DAY SERVICE FLOOR IS WOOD COMPOSIT, CABINETS ARE WOOD WITH HALLOWED ENCLOSED BASES, LAMINATE COUNTER TOPS AND SMOOTH CEILING. ALL ARE FOUND TO BE IN GOOD CONDITION AND

Type: Full
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Page 2

WILL BE MONITORED AT FUTURE INSPECTIONS. IF AT ANY TIME THERE IS FOUND TO BE A RISK OF CONTAMINATION OR CONCERN THE PHYSICAL FACILITIES WILL BE REQUIRED TO BE BROUGHT UP TO CODE.

TEMP:
MILK 41
BERRY 39

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 7994241017 of 02/05/24.

Certified Food Protection Manager: Yasin Abdi

Certification Number: 110554 Expires: 01/14/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
Establishment Representative

Signed: 
Crystal Elva
Public Health Sanitarian 3
St Paul
651-201-3981
Crystal.Elva@state.mn.us

Report #: 7994241017

m

DEPARTMENT OF HEALTH

Minnesota Department of Health

625 Robert Street North

St Paul

No. of RF/PHI Categories Out

1

Date

02/05/24

No. of Repeat RF/PHI Categories Out

0

Time In

11:53:10

Legal Authority MN Rules Chapter 4626

Time Out

Loving Homes Inc

Address

3428 Lee Avenue North

City/State

Crystal, MN

Zip Code

55422

Telephone

7632854303

License/Permit #

0037493

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 complianceOUT= not in complianceN/O= not observedN/A= not applicableCOS=corrected on-site during inspectionR= repeat violation

Compliance Status

COS

R

Supervision

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 Hygienic 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

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 proceeedures 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 complianceMark "X" in appropriate box for COS and/or RCOS=corrected on-site during inspectionR= 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 labeled; 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

Food & non-food contact surfaces cleanable, properly designed, constructed, & used

48

X

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

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: 02/05/24

Inspector (Signature)

