



Protecting, Maintaining and Improving the Health of All Minnesotans

September 29, 2023

Licensee
Scandia Capital Partners LLC
126 98th Avenue West
Duluth, MN 55808

RE: Project Number(s) SL30577015

Dear Licensee:

On September 26, 2023, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the May 25, 2023, 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 cursive script that reads 'Jessie Chenze'.

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

HHH



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
August 10, 2023

Licensee
Scandia Capital Partners LLC
126 98th Avenue West
Duluth, MN 55808

RE: Project Number(s) SL30577015

Dear Licensee:

On August 8, 2023, 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 May 25, 2023. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the May 25, 2023 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey completed on August 8, 2023, found not corrected at the time of the August 8, 2023, follow-up survey and/or subject to penalty assessment are as follows:

2310-Appropriate Care And Services-144g.91 Subd. 4 (a) - \$3,000.00

The details of the violations noted at the time of this follow-up survey completed on August 8, 2023 (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 \$3,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

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

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 the 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.

Please email reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

Please address your cover letter for reconsideration requests to:

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

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 MDH 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. Requests for hearing may be emailed to:

Health.HRD.Appeals@state.mn.us.

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.

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,



Jessie Chenze, Supervisor
State Evaluation Team
Email: jessie.chenze@state.mn.us
Telephone: 218-332-5175 Fax: 651-281-9796

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30577	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 08/08/2023
NAME OF PROVIDER OR SUPPLIER SCANDIA CAPITAL PARTNERS LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 126 98TH AVENUE WEST DULUTH, MN 55808		
(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: Project SL 30577015-1 On August 7, through August 8, 2023, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on May 25, 2023. At the time of the survey, there were 10 residents receiving services under the Assisted Living with Dementia Care 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}			
{0 510} SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the	{0 510}			

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{0 510}	Continued From page 3 national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: No further action required.	{0 510}			
{0 630} SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: No further action required.	{0 630}			
{0 650} SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information:	{0 650}			

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{0 650}	Continued From page 4 (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: No further action required.	{0 650}			
{0 680} SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor;	{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}			
{0 780} SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in	{0 780}			

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{0 780}	Continued From page 6 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: No further action required.	{0 780}			
{0 800} SS=D	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: No further action required.	{0 800}			
{0 810} SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for	{0 810}			

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{0 810}	Continued From page 7 residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: No further action required.	{0 810}			
{0 820} SS=F	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	{0 820}			

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{0 820}	Continued From page 8 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: No further action required.	{0 820}			
{01060} SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section	{01060}			

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{01060}	Continued From page 9 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: No further action required.	{01060}			
{01370} SS=F	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing;	{01370}			

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{01370}	Continued From page 10 (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: No further action required.	{01370}			
{01380} SS=F	144G.61 Subd. 2 (b) Training and evaluation of unlicensed person (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and	{01380}			

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{01380}	Continued From page 11 changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: No further action required.	{01380}			
{01440} SS=D	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and	{01440}			

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{01440}	Continued From page 12 thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: No further action required.	{01440}			
{01500} SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services	{01500}			

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{01500}	Continued From page 13 and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: No further action required.	{01500}			
{01620} SS=E	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the	{01620}			

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{01620}	Continued From page 14 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}			
{01640} SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for	{01640}			

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{01640}	Continued From page 15 Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: No further action required.	{01640}			
{01700} SS=D	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or	{01700}			

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{01700}	Continued From page 16 designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. This MN Requirement is not met as evidenced by: No further action required.	{01700}			
{01730} SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional	{01730}			

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{01730}	Continued From page 17 when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: No further action required.	{01730}			
{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	{01790}			

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{01790}	Continued From page 18 nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility,	{01790}			

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{01790}	Continued From page 19 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}			
{01880} SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: No further action required.	{01880}			
{01910} SS=F	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer 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,	{01910}			

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{01910}	Continued From page 20 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}			
{01940} SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must	{01940}			

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{01940}	Continued From page 21 be current and updated when there are any changes. This MN Requirement is not met as evidenced by: No further action required.	{01940}			
{01960} SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: No further action required.	{01960}			
{02040} SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an	{02040}			

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{02040}	Continued From page 22 approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: No further action required.	{02040}			
{02310} SS=G	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to provide care and services according to acceptable health care, medical or nursing standards for one of one resident (R10) who utilized consumer bed rails. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On, August 7, 2023, at 11:38 a.m., registered nurse/licensed assisted living director in residency (RN/LALDIR)-A stated the licensee had	{02310}			

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{02310}	Continued From page 23 one resident who had a consumer bed rail attached to the mattress which was brought in and installed by family. RN/LALDIR-A stated R10 had a bed rail assessment completed with measurements, family had been educated on the risks and benefits and a bed rail brochure was provided. RN/LALDIR-A stated there was no documentation in R10's record indicating R10's bed rail was installed per manufacture instructions, or the Consumer Product Safety Commission (CPSC) was checked for recalls. RN/LALDIR-A stated she did not have the manufacturer instructions or any information for R10's bed rail. R10's diagnoses included paroxysmal atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow), chronic kidney disease stage four, hypertension (high blood pressure), and glaucoma (eye condition that can cause blindness). R10's Service Plan dated July 31, 2023, indicated R10 received the following services: bathing, transferring, repositioning, medication management, assistance with Thrombi-Embolus Deterrent (TED) compression stocking, housekeeping and laundry. R10's Bed Rail Assessment dated July 30, 2023, indicated R10 had generalized weakness, intermittent confusion and required an upper right sided ¼ bed rail to provide support with transfers and bed mobility. The bed rail measured 42 inches in height from floor to handle, 17.5 inches from floor to bed bar, and 11.5 inches between rails. R10 and R10's family had been educated on the risks and benefits and provided alternatives to the use of bed rails. R10's record lacked the following:	{02310}			

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{02310}	Continued From page 24 -installation and use of the device according to manufacturer's guidelines; and -evidence the licensee referred to the Consumer Product Safety Commission (CSPC) for bed rail recall information. R10's Plan of Care dated July 30, 2023, did not indicate R10 required the use of a bed rail. On August 7, 2023, at 1:36 p.m., the surveyor and RN/LALDIR-A observed and verified R10's consumer bed rail was a black halo shaped metal tubing, which was loosely attached on the upper right side of the bed by a strap underneath R10's mattress. LALDIR-A verified R10's bed rail did not appear it was correctly installed to ensure security and safety. The surveyor and LALDIR-A R10's viewed the CSPC website and compared R10's consumer bed rail to list of recalled bed rails. LALDIR-A stated R10's bed rail looked very similar to the recalled Vaunn Medical Bed Assist Rail model number 876N-SABK-APVM; however, R10's bed rail did not have a make of model number on the bed rail to confirm or exclude from the recall list. LALDIR-A stated she planned to remove R10's bed rail and replace it with an FDA approved bed rail and notify R10's family. The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently Asked Questions (FAQs) indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without	{02310}			

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{02310}	Continued From page 25 assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, "Documentation about a resident's bed rails includes, but is not limited to: - Purpose and intention of the bed rail. - Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail. - The resident's bed rail use/need assessment: - Risk vs. benefits discussion (individualized to each resident's risks): - The resident's preferences: - Installation and use according to manufacturer's guidelines: - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements". Additionally, the MDH website indicated for "consumer beds", the licensees should refer to individual manufacturer's guidelines for appropriate installation, maintenance, and use. In addition, licensees should refer to the Consumer Product Safety Commission (CSPC) for the most up-to-date information related to portable bed side rail recall information. The Assisted Living Resources & Frequently Asked Questions (FAQs) current recommendations for recall include the following "The United States Consumer Product Safety Commission (CSPC) works to save lives and ensure safety by reducing the unreasonable risk of injuries and deaths associated with consumer products, such as portable bed rails. The CSPC posts information on its website related to portable bed rail recalls. Licensees should review	{02310}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30577	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 08/08/2023
NAME OF PROVIDER OR SUPPLIER SCANDIA CAPITAL PARTNERS LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 126 98TH AVENUE WEST DULUTH, MN 55808		
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{02310}	Continued From page 26 the CSPC website regularly for updates on recalled portable bed rails. The opportune time to do this would be with the 90-day assessment due to the requirement included in the uniform assessment tool for assessing assistive devices. The licensee's Side Rail Use policy dated March 17, 2013, indicated the licensee's RN was responsible to ensure the side rails in use were of safe design and properly maintained. Side rails would be used consistent with the manufacturer's recommendations. If the manufacturer's recommendations were not available, the RN would use appropriate nursing judgement related to the implementation of the side rails. No further information was provided.	{02310}			
{02320} SS=D	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: No further action required.	{02320}			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

June 16, 2023

Licensee

Scandia Capital Partners LLC

126 98th Avenue West

Duluth, MN 55808

RE: Project Number(s) SL30577015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on May 25, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the 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. The 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), the MDH may impose fine amounts of either \$1,000 or \$5,000 to licensees who are found to be responsible for maltreatment.

The 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. The 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 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - \$3,000.00

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

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

Please email reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

Please address your cover letter for reconsideration requests to:

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

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 MDH 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. Requests for hearing may be emailed to: **Health.HRD.Appeals@state.mn.us**.

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.

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,



Jessica Chenze, Supervisor
State Evaluation Team
Email: jessica.chenze@state.mn.us
Telephone: 218-332-5175 Fax: 651-281-9796

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30577	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/25/2023
NAME OF PROVIDER OR SUPPLIER SCANDIA CAPITAL PARTNERS LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 126 98TH AVENUE WEST DULUTH, MN 55808		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL30577015 On May 23, 2023, through May 25, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 10 receiving services under the Assisted Living with Dementia Care license. An immediate correction order was identified on May 24, 2023, issued for SL30577015, tag identification 2310. On May 24, 2023, the immediacy of correction order 2310 was removed, however, non-compliance remained at a scope and level of I.	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			

Minnesota Department of Health

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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: Based on interview and record review, the licensee failed to show they met the requirements of licensure, by attesting the managerial officials who oversaw the day-to-day operations understood applicable statutes and rules; nor developed and/or implemented current policies and procedures as required with records reviewed. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on May 23, 2023, at 10:08 a.m. registered nurse/licensed assisted	0 250			

Minnesota Department of Health

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0 250	Continued From page 3 living director in residency (RN/LALDIR)-A and executive director (ED)-B stated they 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, 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, my building(s) must comply with subdivisions 1-3 of the section, as applicable section Laws 2020, 7th Spec. [special] Sess [session]., chpt. [chapter] 1. art. [article] 6, sect. 17. - I have read and fully understand Minn. Stat. sect. 144G.80, 144G.81. and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22, my building(s) must comply with these sections if applicable. - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G. - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659. - Reporting of Maltreatment of Vulnerable Adults. - Electronic Monitoring in Certain Facilities. - I understand pursuant to Minn. Stat. sect. 13.04 Rights of Subjects of Data, the Commissioner will use information provided in this application, which may include an in-person or telephone	0 250			

Minnesota Department of Health

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0 250	Continued From page 4 conference, to determine if the applicant meets requirements for assisted living licensing. I understand I am not legally required to supply the requested information; however, failure to provide information or the submission of false or misleading information may delay the processing of my application or may be grounds for denying a license. I understand that information submitted to the commissioner in this application may, in some circumstances, be disclosed to the appropriate state, federal or local agency and law enforcement office to enhance investigative or enforcement efforts or further a public health protective process. Types of offices include Adult Protective Services, offices of the ombudsmen, health-licensing boards, Department of Human Services, county or city attorneys' offices, police, local or county public health offices. - I understand in accordance with Minn. Stat. sect. 144.051 Data Relating to Licensed and Registered Persons (opens in a new window), all data submitted on this application shall be classified as public information upon issuance of a provisional license or license. All data submitted are considered private until MDH issues a license. - I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659 governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. - I have examined this application and all attachments and checked the above boxes	0 250			

Minnesota Department of Health

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0 250	Continued From page 5 indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct, and complete. I will notify MDH, in writing, of any changes to this information as required. - I attest to have all required policies and procedures of Minn. Stat. chapter 144G and Minn. Rules chapter 4659 in place upon licensure and to keep them current as applicable. Page five was electronically signed by authorized agent (AA)-H on May 12, 2022. The licensee had an assisted living dementia care license, effective May 1, 2023, with an expiration date of April 30, 2024. The licensee failed to ensure the following policies and procedures were developed and/or implemented: (1) requirements in section 626.557, reporting of maltreatment of vulnerable adults; (2) orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; (3) conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate; (4) infection control practices; (5) medication and treatment management; (6) delegation of tasks by registered nurses or licensed health professionals;	0 250			

Minnesota Department of Health

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0 250	Continued From page 6 (7) supervision of registered nurses and licensed health professionals; and (8) supervision of unlicensed personnel performing delegated tasks. As a result of this survey, the following orders were issued 0250, 0480, 0510, 0630, 0650, 0680, 0780, 0800, 0810, 0820, 1060, 1370, 1370, 1380,1440, 1500, 1620, 1640, 1700, 1730, 1790, 1880, 1910, 1940, 1960, 2040, 2310 and 2320, indicating the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.08 to 144G.95. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 250			
0 480 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	0 480			

Minnesota Department of Health

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0 480	Continued From page 7 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 included document titled, Food and Beverage Establishment Inspection Report dated May 23, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 510 SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b) The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure infection control standards were followed during medication administration and by disinfecting shared equipment in between resident use for	0 510		

Minnesota Department of Health

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0 510	Continued From page 8 one of one employee (unlicensed personnel (ULP)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On May 24, 2023, at 7:02 a.m., the surveyor observed ULP-C gather R5's medications, eye drop and enter R5's room. ULP-C administered R5's oral medications and without putting gloves on, ULP-C administered R5's eye drops. ULP-C returned to the office and placed R5's eye drops back into the medication cart. At 7:09 a.m., without performing hand hygiene, ULP-C prepared R6's medications and eye drop, went into the kitchen and put a piece of bread into the toaster then poured a glass of juice. At 7:19 a.m., ULP-entered R6's room with R6's medications, eye drop, toast, and juice, placed the piece of toast and juice on R6's side table. Without performing hand hygiene or putting gloves on, ULP-C administered R6's eye drops and instructed R6 to take her medications while ULP-C changed R6's garbage. ULP-C exited R6's room, disposed of the trash bag and washed hands at the kitchen sink. At 7:22 a.m. ULP-C prepared R1's medications and obtained the automatic blood pressure machine. At 7:28 a.m., ULP-C entered R1's room with R1's medications, checked R1's blood pressure, left medications with R1 to self-administer and exited room.	0 510			

Minnesota Department of Health

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0 510	Continued From page 9 ULP-C returned to the medication cart and placed the blood pressure machine on the cart and placed R1's eye drops in the medication cart. The surveyor did not observe ULP-C perform hand hygiene or disinfect the blood pressure machine. At 7:33 a.m., ULP-C obtained R2's blood pressure using the automatic blood pressure machine. ULP-C returned the blood pressure machine to the medication cart and documented R1's blood pressure. The surveyor did not observe ULP-C perform hand hygiene or disinfect the blood pressure machine. On May 24, 2023, at 7:52 a.m., ULP-C stated she should have put on gloves when administering eye drops, perform hand hygiene in between resident. ULP-C stated she did not disinfect the blood pressure machine in between resident use with disinfecting wipes. On May 24, 2023, at 10:52 a.m., registered nurse/licensed assisted living director in residency (RN/LALDIR)-A stated staff should be disinfecting shared equipment in between use. RN/LALDIR-A stated staff have been trained to wear gloves when administering eye drops and hand hygiene should be performed before preparing medications, and in between administering resident's medications. The licensee's undated Vital Signs Protocol indicated if using an electric blood pressure machine to clean the blood pressure machine with alcohol or disinfectant wipe. The licensee's undated Medication Protocol for Eye Drops indicated to wash hands, gather supplies such as gloves and a tissue, and wash hands after administration.	0 510			

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0 510	Continued From page 10 The licensee's Medication Administration for the Home Health Aide policy, undated, directed to wash hands before preparing medications. The licensee's Hand Hygiene policy dated April 17, 2023, indicated hand washing shall be performed between resident cares and whenever direct physical contact with a resident takes place. Hands should be washed or decontaminated: -before and after direct contact with a resident; -if moving from a contaminated body site to a clean body site during resident cares; -after contact with environmental surfaces or equipment in the immediate vicinity of the resident; -after removing gloves or gowns; and -before eating and after using a restroom. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510			
0 630 SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse.	0 630			

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0 630	Continued From page 11 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for one of one 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 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2's diagnoses included diabetes type 2, chronic heart failure, stage 3 chronic kidney disease, macular degeneration (eye disease that causes vision loss), diverticulosis (bulging pouches in the digestive tract), vertigo (dizziness), and asthma. R2's unauthenticated Service Plan dated May 10, 2023, indicated R2 received medication management, shower assistance, housekeeping, and laundry. On May 24, 2023, at 7:33 a.m., the surveyor observed unlicensed personnel (ULP)-C check R2's blood pressure using an automatic blood pressure machine. R2's record lacked an IAPP which reviewed resident's susceptibility to abuse by another individual, including other vulnerable adults; the	0 630			

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0 630	Continued From page 12 resident's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to the resident and other vulnerable adults, including self-abuse. On May 24, 2023, at 10:27 a.m., registered nurse/licensed assisted living director in residency (RN/LALDIR)-A stated she could not find an IAPP in R2's record and RN/LALDIR-A stated she completed R2's IAPP on May 23, 2023, after the surveyor requested the document. The licensee's Individual Abuse Prevention Plans dated April 17, 2013, indicated an individual abuse prevention plan would be developed for each assisted living resident to include the following: -individualized review or assessment of the resident's susceptibility to be abused by another individual, including other vulnerable adults; -the resident's risk of abusing other vulnerable adults; -specific measures to minimize the risk of abuse to that person and other vulnerable adults: and -measure to minimize the risk of self-abuse, if applicable No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630			
0 650 SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information:	0 650			

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0 650	Continued From page 13 (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure employee records contained the required content for one of one employee (unlicensed personnel (ULP)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-C had a start date of November 9, 2021, to	0 650			

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0 650	Continued From page 14 provide direct care under the licensee's assisted living with dementia care license. On May 24, 2023, at 7:05 a.m., the surveyor observed ULP-C administering R6's morning medications. ULP-C's employee record lacked documentation of annual performance reviews that identify areas of improvement needed and training needs. On May 24, 2023, at 2:30 p.m., registered nurse/licensed assisted living director in residency (RN/LALDIR)-A stated ULP-C employee record lacked annual performance reviews. The licensee's Personnel Records policy dated April 24, 2023, indicated personnel records would be kept up-to-date, and would comply with the assisted living law and other relevant laws. The personnel record for each person would include performance evaluations annually which identify areas of improvement needed training needs. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650			
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff	0 680			

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0 680	Continued From page 15 assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop an emergency preparedness plan (EPP) with all required content, or practice and document testing of the plan at least twice annually as required. This had the potential to affect all residents, staff, and visitors of the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	0 680			

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0 680	Continued From page 16 On May 24, 2023, at approximately 10:00 a.m., executive director (ED)-B stated he was primarily responsible for the development and maintaining the licensee's emergency preparedness plan. The surveyor reviewed the licensee's Emergency Protocol Book dated April 1, 2023, with ED-B and confirmed the EPP lacked the following required information: -development of policies/procedures to address: -policy/procedure on cooperation and collaboration with local, tribal, regional, state and federal EP to maintain integrated response; -procedure for tracking staff, residents and volunteers; -procedure on the use of volunteers; -policy/procedure to system of medical documentation that preserves resident information, protects confidentiality and secures, maintains availability or records; -a communication plan that included: -primary and alternative means for communicating with facility staff, federal, state, regional and local emergency management agencies; -a means to provide information regarding the facility's needs, and its ability to provide assistance to include information about their occupancy; and -emergency prep testing requirements to include participation in annual community full scale exercises and testing of the EP at least twice a year. The licensee's policy on emergency preparedness was requested and was not provided. No further information was provided.	0 680			

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0 680	Continued From page 17	0 680			
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (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 provide interconnected smoke alarms in each sleeping room and outside in immediate vicinity of the sleeping rooms. This deficient condition had the ability to affect all staff and	0 780			

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0 780	Continued From page 18 residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On a facility tour on May 23, 2023, at approximately 11:30 p.m. with executive director (ED)-B it was observed that smoke alarms were installed in the sleeping rooms and interconnected but there were not alarms outside in the immediate vicinity and interconnected with the sleeping rooms. Smoke alarms are required to be installed in sleeping rooms and outside in the immediate vicinity of the sleeping rooms and be interconnected. The activation of one alarm is required to activate all alarms in the sleeping rooms and outside the sleeping rooms. This deficient finding was visually verified by ED-B at the time of discovery. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780			
0 800 SS=D	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the	0 800			

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0 800	Continued From page 19 health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to affect a limited number of residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at 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). Findings include: On a facility tour on May 23, 2023, at approximately 12:00 p.m. with executive director (ED)-B it was observed the cover was missing on the light/ fan in the bathroom of resident room 8. The exhaust fan/ light is required to be maintained with a cover as designed and installed at the time of construction approval. These deficient conditions were visually verified by ED-B accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800			

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0 810	Continued From page 20	0 810		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by:	0 810		

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0 810	Continued From page 21 Based on record review and interview, the licensee failed to maintain the facility's fire safety and evacuation plan with required elements. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). A record review of available documentation and interview were conducted on May 23, 2023, at approximately 10:15 a.m. of documents provided by executive director (ED)-B on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. Findings include: Record review of the available documentation indicated that the fire safety and evacuation plan did not include procedures for employees regarding resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs of each resident for movement or evacuation. Record review of the available documentation indicated that employees did not receive training on the facility fire safety and evacuation plan upon initial hire and twice per year thereafter. Employee training on the fire safety and evacuation plan is required to be conducted and documented separately from fire evacuation drills.	0 810			

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0 810	Continued From page 22 Record review of the available documentation indicated that the licensee did not offer training to residents who are capable of self-evacuation on the proper actions to be taken in the event of a fire in regard to movement, evacuation, and relocation. Written documentation of training provided to residents in regard to actions required for evacuation is required once a year. Record review of the available documentation did not indicate that evacuation drills had been conducted twice per year per shift and least once every other month as required. Documentation was not available for required evacuation drills at the time of record review and interview. All deficiencies were verified by ED-B during the interview at approximately 11:00 a.m. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810			
0 820 SS=F	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.	0 820			

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0 820	Continued From page 23 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide facilities that were not a distinct hazard to life. This had the potential to directly affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). Findings include: On a facility tour on May 23, 2023, at approximately 11:30 a.m. with executive director (ED)-B, it was observed the marked exterior exit doors were provided with locks that required a key code to unlock from the interior in order to exit the facility. During the tour ED-B indicated the marked exterior exit door locks were not fail safe so that activation of a fire alarm system, fire sprinkler system or loss of power releases the door lock for the purpose of exiting in the event of an emergency. Special locking arrangements that secure people in the building are required to fail in the open position in the event of fire alarm, sprinkler system activation or loss of electrical power. On the same facility tour, it was observed that portable space heaters were present in resident rooms 5 and 8 within this dementia care unit. Space heaters are not allowed in sleeping rooms	0 820			

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0 820	Continued From page 24 of dementia care units. It was also observed that a barrel bolt lock installed at the top and into the head jamb of the main front marked exit door was used to secure the facility at night. Marked exit doors are required to release for the purpose of exiting with one operation. This deficient condition was verified by ED-B accompanying on the tour. TIME PERIOD FOR CORRECTION: Two (2) days	0 820			
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to	01060			

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01060	Continued From page 25 provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation to the resident, legal representative, or designated representative for one of one resident (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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:	01060		

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01060	Continued From page 26 R3 was admitted to licensee on April 6, 2023. R3's Service Plan dated April 6, 2023, indicated R3 received medication administration, assistance with blood glucose (sugar) monitoring, and continuous positive airway pressure machine (CPAP- a machine to treat sleep apnea). R3's Nursing Progress Notes indicated on April 7, 2023, R3 went to the emergency department for an evaluation. On April 10, 2023, at 6:30 p.m., the licensee was notified by R3's daughter, R3 had a stroke and was in the intensive care unit. On April 12, 2023, the licensee was notified by the hospital R3 was being transferred to a rehabilitation center for an estimated stay of two-three weeks. On April 17, 2023, at 4:30 p.m., R3 was re-admitted back to the licensee. R3's record lacked documentation R3, R3's legal representative and/or designated representative received an emergency relocation notice and further lacked documentation the notice was provided to the Office of Ombudsman for Long-Term Care. On May 24, 2023, at 4:017 p.m., registered nurse/licensed assisted living director in residency (RN/LALDIR)-A stated R3 did not have documentation an emergency relocation was provided and was she unaware the Ombudsman needed to be notified when a resident was in the hospital for more than four (4) days. The licensee's Notification of Emergency Relocation form requested the following to be completed: -date of relocation; -location and contact information the resident	01060		

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01060	Continued From page 27 transferred; -reason for transfer; -estimated length of transfer; and -notifications of transfer to include resident, legal representative and Ombudsman. The licensee's Emergency Relocation form, undated, indicated when a facility enacts an emergency relocation, the facility must deliver a written notice to the resident, their legal representative, and their designated representative as soon as possible. A written notice should be delivered to the Office of Ombudsman for Long Term Care as soon as possible and within 24 hours if the resident has relocated and not returned to the facility within four days. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060			
01370 SS=F	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing;	01370			

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01370	Continued From page 28 (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure training and competency evaluations included all the required training for one of one (unlicensed personnel (ULP)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when	01370			

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01370	Continued From page 29 problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on May 23, 2023, at 10:08 a.m., registered nurse/licensed assisted living director in residency (RN/LALDIR)-A stated new employees were required to take all Educare training (online education courses) prior to training on the floor with another ULP. ULP-C had a start date of November 9, 2021, to provide direct care under the licensee's assisted living with dementia care license. On May 24, 2023, at 7:05 a.m., the surveyor observed ULP-C administering R6's morning medications. ULP-C's employee file contained "Protocols for Licensee's Training and Competency" undated document did not identify training and competencies completed by ULP-C with RN/LALDIR -A. ULP-C's employee record lacked evidence ULP-C had received the following training and competencies: -standby assistance techniques and how to perform them; -preparation of modified diets as ordered by a licensed health professional; and -awareness of commonly used health technology equipment and assistive devices. On May 24, 2023, at 2:30 p.m., RN/LALDIR-A stated new staff go through Educare training prior to working on the floor; however, ULPs were not	01370			

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01370	Continued From page 30 competency tested standby assistance, modified diets, commonly used health technology equipment and assisted devices.. RN/LALDIR-A stated it was her understanding competency testing was not needed in those identified areas since staff were not completing those specific tasks. The licensee's Personnel Records policy dated April 24, 2023, indicated the personnel record for each person would include a record of all required training for unlicensed personnel and competency evaluations. The licensee's Staff Competency policy dated August 1, 2021, indicated unlicensed personnel may not work for the licensee until they have successfully passed the written competency test and demonstrated competency evaluations for the following: -standby assistance techniques and how to perform them; -preparation of modified diets as ordered by a licensed health professional; and -awareness of commonly used health technology equipment and assistive devices. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		
01380 SS=F	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting	01380		

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01380	Continued From page 31 resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure training and competency evaluations included all the required training for one of one employee (unlicensed personnel (ULP)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on May 23, 2023, at 10:08 a.m., registered nurse/licensed assisted living director in residency (RN/LALDIR)-A stated new employees were required to take all Educare training (online education courses) prior to training on the floor with another ULP.	01380			

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01380	Continued From page 32 ULP-C had a start date of November 9, 2021, to provide direct care under the licensee's assisted living with dementia care license. On May 24, 2023, at 7:05 a.m., the surveyor observed ULP-C administering R6's morning medications. At 7:33 a.m., the surveyor observed ULP-C monitor R2's blood pressure with the automatic blood pressure cuff. ULP-C's employee record contained "Protocols for Licensee's Training and Competency" undated document that did not identify training and competencies ULP-C completed with RN/LALDIR-A. ULP-C's employee record lacked evidence ULP-C had received the following training and competencies: -safe transfer techniques and ambulation; and -range of motioning and positioning. On May 24, 2023, at 2:30 p.m., RN/LALDIR-A stated new staff go through Educare training prior to working on the floor; however, ULPs were not competency tested on transfers, ambulation, or range of motion (ROM). RN/LALDIR-A stated if a resident had an order for ROM, therapy would have to provide the service. RN/LALDIR-A further stated it was her understanding competency testing was not required in the areas listed above since the licensee's residents did not require assistance with transfers, ambulation, ROM or positions and the staff were not completing those tasks. The licensee's Personnel Records policy dated April 24, 2023, indicated the personnel record for each person would include a record of all required training for unlicensed personnel and	01380			

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01380	Continued From page 33 competency evaluations. The licensee's Staff Competency policy dated August 1, 2021, unlicensed personnel may not work for the licensee until they have successfully passed the written competency test and the following must be completed by a practical skills test: -safe transfer techniques and ambulation; and -range of motioning and positioning. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380		
01440 SS=D	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and	01440		

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01440	Continued From page 34 thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure direct supervision of staff performing delegated tasks was provided within 30 calendar days after the date on which the individual begins working for the licensee for one of one (unlicensed personnel (ULP)-F). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-F had a start date of January 17, 2023, to provide direct care under the licensee's assisted living with dementia care license. On May 24, 2023, at 2:30 p.m., registered nurse/licensed assisted living director in residency (RN/LALDIR)-A stated she was unable to find where ULP-F had a 30-day supervision completed as required. The licensee's Personnel Records policy dated April 24, 2023, indicated the personnel record for each person would include results of supervision observations.	01440			

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01440	Continued From page 35 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01440		
01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning	01500		

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01500	Continued From page 36 and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure an employee received all of the required annual training content for each 12 months of employment for one of one employee (unlicensed personnel (ULP)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or	01500			

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01500	Continued From page 37 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-C had a start date of November 9, 2021, to provide direct care under the licensee's assisted living with dementia care license. On May 24, 2023, at 7:05 a.m., the surveyor observed ULP-C administering R6's morning medications. ULP-C's employee record did not include annual training for the review of provider's policies and procedures. On May 24, 2023, at 2:30 p.m., registered nurse/licensed assisted living director in residency (RN/LALDIR)-A stated she was unable to find where ULP-C had completed the above noted annual training for 2022. The licensee's Personnel Records policy dated April 24, 2023, indicated the personnel record for each person would include record of required in-service education for all staff providing services to residents, including annual training. The licensee's Assisted Living with Dementia Care Annual Training policy dated August 1, 2021, indicated direct care staff would complete eight hours of annual training for each 12 months of employment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500		

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01620	Continued From page 38	01620			
01620 SS=E	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs 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 which included all required assessment content not to exceed 90 days from previous assessment for two of two residents (R1, R2).	01620			

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01620	Continued From page 39 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: R1 R1's started receiving assisted living services by the licensee August 2, 2022. R1 diagnoses included Alzheimer's, diabetes, hypothyroidism (low thyroid levels), and congested heart failure (CHF). R1's Service plan dated August 8, 2022, indicated R1 received medication management and storage, assistance with Thromb-Embolus Deterrent (TED) compression stocking, housekeeping, and laundry. On May 24, 2023, at 7:22 a.m., the surveyor observed unlicensed personnel (ULP)-C prepare R1's morning medications for administration. R1's Client Evaluation dated September 7, 2022, did not include a comprehensive assessment using the uniform assessment tool included all the required content. Further, R1's record did not include ongoing comprehensive assessments completed by the RN. No further comprehensive assessments were completed by the RN. R2	01620			

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01620	Continued From page 40 R2's started receiving assisted living services by the licensee April 22, 2022. R2's diagnoses included diabetes type 2, chronic heart failure, stage 3 chronic kidney disease, macular degeneration (eye disease that causes vision loss), diverticulosis (bulging pouches in the digestive tract), vertigo (dizziness), and asthma. R2's unauthenticated Service Plan dated May 10, 2023, indicated R2 received medication management, bathing, housekeeping, and laundry. On May 24, 2023, at 7:00 a.m., the surveyor observed ULP-C enter R2's room and leave a medication cup full of R2's morning medications in R2's room to self-administer. R2's Client Evaluation dated September 8, 2022, did not include a comprehensive assessment using the uniform assessment tool that included all the required content. Further, R2's record did not include ongoing comprehensive assessments completed by the RN. No further comprehensive assessments were completed by the RN. On May 24, 2023, at 10:27 a.m., registered nurse/licensed assisted living director in residency (RN/LALD)-A stated R1 and R2's assessments using the Client Evaluation form were no comprehensive assessments and were the last assessment completed by the RN. RN/LALDIR-A stated she was in the process of going through all resident records to ensure resident assessments were current and included a comprehensive assessment using the content from the uniform assessment tool. Per Assisted Living Facilities: Minnesota Rules	01620		

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01620	Continued From page 41 Chapter 4659, 4659.0150, Subp. 2. Assessment tool elements, each facility must develop a uniform assessment tool. The facility may use any acceptable form or format for the tool, such as an online or a hard-copy paper assessment, as long as the tool includes the elements identified in this subpart 2, A-O. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan.	01640		

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01640	Continued From page 42 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the service plan included a signature or other authentication by the resident and/or resident's representative to document agreement on the services to be provided for one of one 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 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2's Service Plan, Part 1- Rate Sheet Agreement and Part 2 Service Plan signed by the licensee's representative May 10, 2023, did not include a signature or other authentication by R2 or R2's representative documenting agreement on the services provided. R2's service plan indicated R2 received medication management, bathing, housekeeping, and laundry. On May 24, 2023, at 7:00 a.m., the surveyor observed unlicensed personnel (ULP)-C prepare and bring R2's scheduled morning medications and leave with R2 to self-administer at a later time. On May 24, 2023, at 10:27 a.m., registered nurse/licensed assisted living director in residency (RN/LALDIR)-A stated R2's service plan was not signed by the resident or resident's	01640			

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01640	Continued From page 43 representative and was waiting for R2's Power of Attorney (POA) to sign. RN/LALDIR-A stated R2 was able to sign her own paperwork but preferred to have someone she trusted present due to her poor eyesight. RN/LALDIR-A stated there was no documentation in R2's record indicating R2's POA was contacted to sign R2's service plan. The licensee's Contents of Service Plans policy dated April 17, 2023, indicated service plans and any revisions to service plans would have a signature or other authentication by the facility and by the resident. Other authentication could be email confirmation accepting terms of a service agreement or other method deemed appropriate by the assisted living. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640			
01700 SS=D	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications,	01700			

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01700	Continued From page 44 allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure residents were assessed for self-administration of medications for one of one resident (R2) who self-administered medications after medication setup. 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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2's diagnoses included diabetes type 2, chronic heart failure, stage 3 chronic kidney disease, macular degeneration (eye disease that causes vision loss), diverticulosis (bulging pouches in the digestive tract), vertigo (dizziness), and asthma.	01700			

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01700	Continued From page 45 On May 24, 2023, at 7:00 a.m., the surveyor observed unlicensed personnel (ULP)-C enter R2's room and leave a medication cup full of R2's morning medications in her room to self-administer. ULP-C stated R2 was able to take her medications and insulin on her own after setup. R2's unauthenticated Service Plan dated May 10, 2023, directed to "See Medication Management Plan." R2's undated and unauthenticated Medication Management Plan: Addendum to Service Plan, indicted R2 received medication administration and medication storage. R2's plan did not indicate R2 was able to self-administer medications after set up. R2's May 2023, care plan indicated R2 received medication administration and storage. R2 was able to self-administer insulin under staff supervision after staff confirmed correct dose was prepared. R2's prescriber orders dated May 11, 2023, included the following medications; -calcium 600 milligrams (mg) daily for supplementation; -furosemide 40 mg daily to treat swelling ; -Levemir 30 units (long-acting insulin) subcutaneous (injection into the fatty tissue under the skin) daily; -Isosorbide 30 mg daily for high blood pressure; -levothyroxine 100 micrograms (mcg) daily for low thyroid level; -Losartan 25 mg daily for high blood pressure; -simvastatin 20 milligrams (mg) by mouth at bedtime for high cholesterol; -acetaminophen 650 mg twice a day for pain;	01700			

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01700	Continued From page 46 -Systane solution to both eyes twice a day for dry eyes; -Albuterol Sulfate solution 2.5 mg/3 ml inhale twice a day for shortness of breath; and -Salonpas topical patch one (1) patch to affected area as needed for pain/muscle tension. R2's prescriber orders did not include an order for self-administration of medications. R2's Medication Administration Record (MAR) dated May 1 through May 31, 2023, indicated R2 was able to keep the following medications in room and self-administer: -nebulizer solution (a small machine that turns liquid medicine into a mist that is inhaled); -Salonpas topical pain patches; -Systane eye drops; and -Levemir insulin pen. R2's MAR did not indicate to leave all other prescribed medications in R2's room to self administer after setup. R2's record lacked a self-medication assessment to determine R2 was able to correctly and safely self-administer insulin, eye drops, pain patch, and inhaled medications. On May 23, 2023, at 12:40 p.m., R2 stated the licensee provided meals, activities, housekeeping, laundry, and managed her medications. R2 stated kept her insulin, eye drops, pain patches and nebulizer solution in her room to self-administer. R2 stated staff prepared her medications and left with her to take on her own. On May 24, 2023, at 10:27 a.m., registered nurse /licensed assisted living director in residency (RN/LALDIR)-A stated R2 was able store and self-administer her own eye drops, nebulizer, pain	01700		

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01700	Continued From page 47 patch and under the supervision of staff her insulin. R2 stated R2 had not been assessed to determine R2 could appropriately and safely administer her insulin, eye drops, nebulizer, or pain patch. The licensee's Medication Management Program policy dated April 24, 2023, indicated the medication management program was at the discretion of the registered nurse based on a professional face-to-face assessment to include resident's ability in medication self-management and storage/security of medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01700		
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications;	01730		

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01730	Continued From page 48 (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure sure an individual medication management plan was followed for one of one resident (R2) who stored medications in their apartment. 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	01730			

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01730	Continued From page 49 situation has occurred only occasionally). The findings include: On May 23, 2023, at 10:08 a.m., during entrance conference, registered nurse/licensed assisted living director in residency (RN/LALDIR)-A stated the licensee provided medication management services to include secured medication storage. On May 24, 2023, at 7:00 a.m., the surveyor observed unlicensed personnel (ULP)-C enter R2's room and leave a medication cup full of R2's morning medications in her room to self-administer. ULP-C stated R2 was able to take her medications and insulin on her own after setup. R2's diagnoses included diabetes type 2, chronic heart failure, stage 3 chronic kidney disease, macular degeneration (eye disease that causes vision loss), diverticulosis (bulging pouches in the digestive tract), vertigo (dizziness), and asthma. R2's unauthenticated Service Plan dated May 10, 2023, directed to "See Medication Management Plan." R2's undated and unauthenticated Medication Management Plan: Addendum to Service Plan, indicated R2 received medication administration and medication storage. R2's medication plan indicated R2's medications were to be stored in the medication cart, secured refrigerator, and bulk locker. R2's May 2023, Care Plan indicated medications were to be stored in the medication cart and locked in the refrigerator.	01730			

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01730	Continued From page 50 R2's May 2023, Medication Administration Record (MAR) indicated R2's nebulizer solution, Salonpas topical patch, Systane eye drops, and Levemir Flex insulin pen were to be stored in R2's room to self-administer. On May 23, 2023, at 12:40 p.m., R2 stated the licensee provided meals, activities, housekeeping, laundry, and managed her medications. R2 stated kept her insulin, eye drops, pain patches and nebulizer solution in her room to self-administer. R2 stated staff prepared her medications and left with her to take on her own. On May 24, 2023, at 2:30 p.m., RN/LALDIR-A stated R2 was able to store her eye drops, insulin, nebulizer solution and pain patches in her room to self-administer which was indicated on R2's MAR. RN-LALDIR-A stated R2's Medication Management Plan should have been updated to indicate R2 was able to keep the medications indicated above in her room. The licensee's Medication Management Program policy dated April 24, 2023, indicated the medication management program was at the discretion of the registered nurse based on a professional face-to-face assessment to include resident's ability in medication self-management and storage/security of medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730			
01790 SS=F	144G.71 Subd. 10 Medication management for residents who will	01790			

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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
01790	Continued From page 51 (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 provided, including documenting the date the	01790			

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01790	Continued From page 52 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 written procedures with all the required content for 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 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).	01790			

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01790	Continued From page 53 The findings include: On May 23, 2023, at 10:08 a.m., during entrance conference, registered nurse/licensed assisted living director in residency (RN/LALDIR)-A stated the licensee provided medication management services to include unplanned time away. RN/LALDIR-A stated the ULPs were trained to prepare and send medications with residents for unplanned times away when the nurse was unavailable. The surveyor requested a copy of the licensee's unplanned time away policy and procedure to review. The licensee lacked a written procedure for unplanned and planned time away to include: - the type of container or containers to be used for the medications appropriate to the provider's medication system; and - how the ULP 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. On May 25, 2023, at 11:36 a.m., the surveyor reviewed the licensee's Medication Management Plan for Clients Away from Home policy and Time Away Medication Setup Form, undated, with RN/LALDIR-A. RN/LALDIR-A stated the policy and procedure indicated to place the medications in a suitable container and did not specify type of container and did not include how to document unused medications that were returned to the licensee. The license's Medication Management Plan for Clients Away from Home policy dated March 17, 2023, referenced MN Statue 144A.4792 and indicated as part of the Medication Management	01790			

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01790	Continued From page 54 Program, the licensee would arrange for the safe provision of medications for clients with planned/unplanned times away from home. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790			
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure refrigerated medications were maintained at manufacturer recommended temperatures by failing to monitor and document medication refrigerator temperatures for one of one medication refrigerator. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include:	01880			

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01880	Continued From page 55 On May 24, 2023, at 4:35 p.m. the surveyor observed the medication refrigerator with registered nurse/licensed assisted living director in residency (RN/LALDIR)-A. RN/LALDIR-A stated the internal thermometer indicated 48 degrees Fahrenheit (F). On top of the refrigerator were temperature logs dated February 2022, to June 2022. RN/LALDIR-A reviewed the temperature logs and stated the last temperature was recorded on May 19, 2022, and there were no further recorded temperatures. RN/LALDIR-A stated staff should be monitoring and recording the refrigerator temperatures at a minimum of daily. During the above observation, RN/LALDIR-A verified the following resident medications were being stored: -three (3) Levemir insulin pens 100 units (u)/milliliters (ml) (long-acting insulin) for R2; -10 unopened and one (1) partially used Tresiba Flex Touch insulin pens 200 u/ml (long-acting insulin) for R3; -one (1) unopened Praluent injection pen 75 milligrams (mg)/ml (used to treat cardiovascular disease) for R3; -two (2) unopened Trulicity injection pen 0.75 mg (non-insulin injection to treat diabetes) for R3; -five (5) unopened Novolog Flex insulin pens 100 u/ml (rapid acting insulin) for R3; and -one (1) unopened Ozempic injection pen 2 mg/3 ml (non-insulin injection used to treat diabetes) for R3. The manufacturer's instructions for Levemir insulin dated September 2022, indicated to store unopened Levemir in the refrigerator at 36-46 degrees F and do not freeze. The manufacturer's instructions for Tresiba	01880			

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01880	Continued From page 56 insulin pen dated July 2022, indicated to store unopened Tresiba in the refrigerator at 36-46 degrees F and do not freeze. The manufacturer's instructions for Praluent injection pen dated indicated to store unopened Praluent in the refrigerator at 36-46 degrees F and do not freeze. The manufacturer's instructions for Trulicity injection pen dated September 2018, indicated to store unopened Trulicity in the refrigerator at 36-46 degrees F and do not freeze. The manufacturer's instructions for Novolog insulin pen dated November 2021, indicated to store unopened Novolog in the refrigerator at 36-46 degrees F and do not freeze. The manufacturer's instructions for Ozempic injection pen dated 2022, indicated to store unopened Ozempic in the refrigerator at 36-46 degrees F and do not freeze. The licensee's Individual Medication Management Plan policy dated January 2022, indicated if the licensee stored the resident's medications, the medications would be stored at the temperature recommended by the manufacturer. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880			
01910 SS=F	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the	01910			

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01910	Continued From page 57 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 required content on disposition of the medications for one of one resident (R4) upon discharge. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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:	01910			

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01910	Continued From page 58 R4 was discharged on May 5, 2023. R4's signed prescriber orders dated April 30, 2022, directed to start the following medications: -morphine concentrate liquid 100 milligrams (mg)/5 milliliters (ml) give 0.25 ml (5 mg) by mouth every two (2) hours for pain or shortness of breath; and -morphine concentrate liquid 100 mg/5 ml give 0.25 ml (5 mg) by mouth every 30 minutes as needed for increased pain. R4's May 2022, Medication Administration Record indicated R4 received the following medications: -morphine concentrate liquid 100 mg/5 ml give 0.25 ml (5 mg) by mouth every two (2) hours for pain or shortness of breath; and -morphine concentrate liquid 100 mg/5 ml give 0.25 ml (5 mg) by mouth every 30 minutes as needed for increased pain. R4's PRN Medication Administration Record and Response documentation indicated R4 received 0.25 ml of morphine concentrate on May 4, 2022, at 1:46 a.m. R4's Narcotic Count Record indicated on May 4, 2022, at 8:00 p.m., R4 had 24.75 ml of morphine sulfate oral solution remaining. R4's Discharge Summary dated May 5, 2023, indicated R4 received assistance with medication administration and storage. R4's summary further indicated R4's morphine concentrate 100 mg/ five (5) mg was destroyed and signed by registered nurse/licensed assisted living director in residency (RN/LALDIR)-A. R4's record lacked the documentation of R4's morphine to include:	01910		

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01910	Continued From page 59 -the prescription number; -strength; -quantity disposed; -to whom the medications were given to or how the medications were destroyed; and -and names of staff and individuals involved in the disposition. On May 25, 2023, p.m., RN/LALDIR-A stated the licensee did not destroy narcotics onsite and all narcotics were brought to the police department for destruction by her and another staff member. RN/LALDIR-A stated R4's morphine sulfate was brought to the police department for destruction by RN/RALD and human resources (HR)-G. RN/LALDIR-A stated she was unable to find documentation in R4's record to support the above statement. RN/LALDIR-A reviewed the licensee's Non-Narcotic Medication Disposition/Disposal Record and confirmed the form was lacking to whom the medications were given to or how the medications were destroyed. The licensee's Disposition or Disposal of Medications policy dated April 17, 2023, indicated discontinued controlled medications that are managed by the facility would be disposed of by flushing or making them nonpalatable per facility protocol. The registered nurse (RN) or licensed practical nurse (LPN) and a second personas witness would document the disposal. The controlled substance must be documented in the resident's electronic medical record (EMR) or an agency approved form. Documentation of the destruction, listing the date, quantity, name of the drug, prescription number, signature of the person destroying the drugs and signature of the witness of the destruction must be recorded and maintained in the resident's record for two years.	01910			

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01910	Continued From page 60 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910			
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes.	01940			

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01940	Continued From page 61 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to include a written statement of treatment or therapy services to be provided on the service plan to include daily monitoring of blood glucose, weights, and blood pressures for one of one resident (R2). In addition, the licensee failed to ensure unlicensed personnel (ULP)-C followed the treatment plan for one of one resident (R2) who had a blood pressure out of range. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On May 23, 2023, at 10:08 a.m., during the entrance conference registered nurse/licensed assisted living director in residency (RN/LALDIR)-A stated the licensee provided treatment and therapy services to residents at the facility. R2's diagnoses included diabetes type 2, macular degeneration (eye disease that causes vision loss), chronic heart failure, and stage three chronic kidney disease. R2's prescriber orders dated May 11, 2023, indicated weights and blood glucose checks daily, and weekly blood pressure monitoring.	01940			

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01940	Continued From page 62 On May 23, 2023, at 12:40 p.m., R2 stated she checked her own weight and blood glucose daily and recorded the results. R2 stated some staff checked her blood pressure and would ask what her weight and blood glucose results were for that day; however, it was inconsistent and not completed daily. On May 24, 2023, at 7:33 a.m., ULP-C and the surveyor entered R2's room. R2 was in the bathroom checking her weight. The surveyor observed ULP-C check R2's blood pressure using an automatic blood pressure machine with a blood pressure reading was 176/112 millimeters of mercury (mm HG) and pulse 104. At 7:35 a.m., ULP-C rechecked R2 blood pressure and obtained a reading of 166/95 and pulse 89. R2 stated she was having some pain that morning and maybe that was why her blood pressure was elevated. ULP-C asked R2 what her weight was that morning and R2 reported 215 pounds. ULP-C stated R2 checked her own blood glucose and recorded her results. ULP-C did not ask R2 what her blood glucose results were that morning. ULP-C stated she planned to notify RN/LALDIR-A of R2's elevated blood pressure. ULP-C returned to the office and documented R2's blood pressure and weight on R2's Daily Monitoring Flowsheet. ULP-C verified R2's Treatment Record and Daily Monitoring Flowsheet did not direct staff to record R2's blood glucose results. R2's unauthenticated Service Plan dated May 10, 2023, directed to "See Treatment Pan." R2's Treatment Plan: Addendum to Service Plan, undated, did not include a statement of treatment and therapy services to include blood glucose monitoring, daily weights, or weekly blood	01940			

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01940	Continued From page 63 pressure monitoring. R2's May 2023 Treatment Record directed to monitor R2's blood pressure and heart rate weekly, check weight daily before breakfast and record results. R2's Treatment record did not include daily blood glucose monitoring. R2's May 2023 Daily Monitoring Flow sheet directed to check R2's blood pressure and weight daily; however, lacked daily blood glucose monitoring. On May 24, 2023, at 10:27 a.m., RN/LALDIR-A stated R2 received daily blood pressure checks by staff and R2 checked her own blood glucose and weight daily and staff were to record results on R2's Treatment Record and Daily Monitoring Flow sheet. RN/LALDIR-A reviewed R2's May Treatment Record and stated R2's Treatment Record indicated to check R2's blood pressure weekly and not daily; however, did include to record R2's blood glucose reading. RN/LALDIR-A reviewed R2's May Daily Monitoring Flow sheet and stated R2's flow sheet directed to check R2's blood pressure and weight daily; however, did not include recoding R2's blood glucose reading daily after R2 checked her blood glucose. RN/LALDIR-A stated she could see how R2's directions were unclear on services and how often staff were to be monitoring and documenting R2's blood glucose, weights and blood pressure. On May 24, 2023, at 10:52 a.m., RN/LALDIR-A stated she was not informed by staff R2's blood pressure reading was out of range that morning (May 24, 2023). On May 25, 2023, at 12:15 p.m. RN/LALDIR-A	01940			

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01940	Continued From page 64 provided the surveyor with R2's Treatment Plan: Addendum to Service Plan and stated she had R2 sign and updated R2's Treatment Plan to include R2 was able to monitor on own blood glucose and staff were to record results daily; however, had not been updated to include daily weights and blood pressure monitoring. The licensee's Vital Signs Protocol, undated, indicated if using the electronic blood pressure cut to notify the nurse if the top number of the blood pressures over 150 or below 90 and the bottom number is over 100 or below 60. The licensee's Emergencies and Nurse Call Protocols dated May 2, 2023, indicated to always call the nurse if the systolic blood pressure (top number) is over 150 or below 100 and if diastolic lower number pressure (lower number) is over 90 or below 50 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940			
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided	01960			

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01960	Continued From page 65 to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure treatment or therapy services were documented for one of one 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 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2's diagnoses included diabetes type 2, macular degeneration (eye disease that causes vision loss), chronic heart failure, and stage three chronic kidney disease. R2's prescriber orders dated May 11, 2023, indicated daily weights and blood glucose checks, and weekly blood pressure monitoring. R2's unauthenticated Service Plan dated May 10, 2023, directed to "See Treatment Pan." R2's Treatment Plan: Addendum to Service Plan, undated, did not include a statement of treatment and therapy services to include blood glucose monitoring, daily weights, or weekly blood pressure monitoring. Further, R2's treatment plan did not indicate R2 was able to check own blood glucose and weight and staff were to record	01960			

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01960	Continued From page 66 results in R2's medical record. On May 24, 2023, at 7:33 a.m., unlicensed personnel (ULP)-C and the surveyor entered R2's room. R2 was in the bathroom checking her weight. The surveyor observed ULP-C check R2's blood pressure using an automatic blood pressure machine with a blood pressure reading was 176/112 millimeters of mercury (mm HG) and pulse 104. At 7:35 a.m., ULP-C rechecked R2 blood pressure and obtained a reading of 166/95 and pulse 89. ULP-C asked R2 what her weight was that morning and R2 reported 215 pounds. ULP-C stated R2 checked her own blood glucose and recorded her own results. ULP-C did not ask R2 what her blood glucose results were that morning. ULP-C returned to the office and documented R2's blood pressure and weight on R2's Daily Monitoring Flowsheet. ULP-C verified R2's Treatment Record and Daily Monitoring Flowsheet did not direct staff to record R2's blood glucose results. ULP-C stated she was the only staff who recorded R2's daily weight and blood pressure. R2's May 2023 Care Plan, indicated to check R2's weight and blood pressure daily; blood glucose daily in the morning and report signs and symptoms of hypo/hyperglycemia (low/high blood glucose) to registered nurse (RN). R2's May 2023 Treatment Record directed to monitor R2's blood pressure and heart rate weekly and to notify the provider if R2's systolic blood pressure (upper number) was routinely below 100 and pulse below 60. R2's Treatment Record indicated to check weight daily before breakfast and record results; however, did not indicate to record R2's blood glucose readings.	01960			

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01960	Continued From page 67 R2's Daily Monitoring Flow sheet from May 1 through May 31, 2023, included daily monitoring blood pressure and weight daily; however, lacked documentation R2 received blood pressure checks 13 out of 24 opportunities and lacked documentation R2 received recorded weights 15 missed out of 24 opportunities. On May 24, 2023, at 10:27 a.m., registered nurse/licensed assisted living director in residency (RN/LALDIR)-A reviewed R2's records confirmed R2's record was missing documentation of daily recorded weights and blood pressures and did not include to record R2's blood glucose checks. RN/LALDIR-A stated staff were expected to record R2's weight, blood pressure and blood glucose results daily. The licensee's treatment documentation policy was requested and not received. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an	02040		

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02040	Continued From page 68 approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to provide a hazard vulnerability assessment or safety risk assessment of the physical environment on and around the property. This deficient practice had the ability to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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). Findings include: A record review of available documentation and interview were conducted May 23, 2023, at approximately 11:00 a.m. with executive director (ED)-B on the hazard vulnerability assessment for the physical environment of the facility. Record review of the available documentation indicated that the licensee had not performed a hazard vulnerability assessment with mitigation factors on and around this specific property. This deficient condition was verified by ED-B during the interview at approximately 11:15 a.m. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	02040			

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02310	Continued From page 69	02310		
02310 SS=I	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards for one of one resident (R1) with side rails that lacked a comprehensive side rail assessment to include side rail measurements and ongoing side rail assessments to determine safety and appropriate use. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). This resulted in an immediate correction order identified on May 24, 2023. The findings include: On May 23, at 10:08 a.m., during entrance conference, registered nurse/licensed assisted living director in residency (RN/LALDIR)-A stated	02310		

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02310	Continued From page 70 there was one resident who had a hospital bed with attached bed rails. RN/LALDIR-A stated resident with bed rails would require physician orders, a bed rail assessment with measurements, a information regarding the risk vs benefits. RN/LALDIR-A further stated the side rail assessment would be completed every 90 days. R1 diagnoses included Alzheimer's, diabetes, hypothyroidism (low thyroid levels), and congested heart failure (CHF). R1's Service Plan dated August 2, 2022, R1 received the following services: bathing, transferring in and out of bed, medication management, assistance with Thromb-Embolus Deterrent (TED) compression stocking, housekeeping and laundry. R1's 90-day assessment dated May 1, 2023, did not include the use of side rails. R1's Care Plan dated April 28, 2023, indicated R1 had bilateral 1/2 rails in place at all times. R1's Side-Rail Assessment dated June 8, 2022, indicated R1 had ½ rails on R1's bed that were in compliance with the FDA bed safety guidelines and R1 and/or R1's family had been educated on the benefits and risks. R1's Side-Rail Assessment and R1's medical record lacked documentation of the side rail measurements to ensure R1's side rails met FDA (Food and Drug Administration) recommended guidelines to reduce the risk of entrapment. On May 23, 2023, at 12:33 p.m., RALD-A stated R1's medical record did not include documentation of R1's side rail measurements. RALD-A stated	02310		

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02310	Continued From page 71 R1's side rails had not been assessed since June 8, 2022. RALD-A stated R1's medical record lacked documentation R1 and/or R1's representative received information on the risk and benefits of the use of side rails. On May 23, 2023, at 1:04 p.m., the surveyor observed R1 sitting in her chair in her room. R1 had a hospital bed with attached 1/2 side rails in the upright position, on both sides of the bed located near the head of the bed. R1 stated she had the hospital bed before she moved in and she used the side rails to assist in getting in and out of bed. The March 10, 2006, FDA Side Rail Entrapment Zones and Dimensional Recommendations indicated to reduce the risk of entrapment, zone 1 (within the rail) should not exceed 4 and 3/4 inches, zone 2 (under the rail, between rail supports or next to a single rail support) should not exceed 4 and 3/4 inches, zone 3 (between the rail and the mattress), should not exceed 4 and 3/4 inches, and zone 4 (under the rail, at the ends of the rail) should not exceed 2 and 3/8 inches or be greater than a 60 degree angle. The FDA, "A Guide to Bed Safety" revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe."	02310			

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02310	Continued From page 72 The licensee's Side Rail Use policy dated May 9, 2019, indicated before implementing side rails for a client, the RN (registered nurse) would conduct a side rail assessment that included the following: -level of mobility, including bed mobility -level of consciousness -level of cognition -presence of orthostatic hypotension; and -vision. The policy further indicated if the need for side rails was indicated and the client/family agreed to the use, the RN would provide education related to side rails. The RN would document the purpose of the side rails and the education provided. The client/family would co-sign the document agreeing to the risks and benefits of the side rails. The need for side rails would be assessed and documented as needed, but not less than every 90 days, No further information was provided. TIME PERIOD FOR CORRECTION: Immediate Immediacy is removed as confirmed by surveyor's on-site observation and review by evaluation supervisor on May 24, 2023, however, non-compliance remains at a scope and level of level three, widespread (I).	02310		
02320 SS=D	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the	02320		

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02320	Continued From page 73 services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to provide care and services according to acceptable health care medical or nursing standards for medication administration by unlicensed personnel (ULP)-C for two of two residents (R6, R1) whose medications were documented prior to administration, for three of three residents (R7, R8, R9) whose medications were left with the residents, and for one of one resident (R5) whose medications were set up to administer at a late time. 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: R6 R6's diagnoses included Alzheimer's. R6's Medication Management Plan: Addendum to Service Plan dated May 23, 2023, indicated R6 received medication administration and storage. R6 prescriber's orders dated May 11, 2023, included the following medications one eye drop, two anti-depressants, one anti-anxiety, one	02320			

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02320	Continued From page 74 supplement, two pain medications, one medication to treat heart burn, one heart medication, two medications to treat constipation, one medication to treat high blood pressure, one medication to treat high cholesterol, one medication to treat ulcers, one medication to treat low potassium, and one medication to treat insomnia. On May 24, 2023, at 7:05 a.m., the surveyor observed ULP-C prepare the following medications for R6's for administration: -bupropion HCL 300 milligrams (mg) one (1) tablet (antidepressant); -fluoxetine 20 mg one (1) capsule (antidepressant); -sucralfate 1 gram (gm) one (1) tablet (used to treat ulcers); -clopidogrel 75 mg one (1) tablet (blood thinner); -acetaminophen 325 mg two (2) tables (pain reliever); -magnesium 15 mg one (1) capsule (supplement); -omeprazole 20 mg one (1) capsule (used to treat heartburn); and -bupropion 150 mg one (1) tablets along with 300 mg tablet (antidepressant). ULP-C dispensed R6's medications into a medication cup and was not observed to check R6's MAR with the medications labels for directions prior to placing the medications in the medication cup. ULP-C stated she had the resident's medications memorized so sometimes she doesn't check the resident's medication labels against the MAR prior to dispensing unless it was a new medication. ULP-C documented in R6's Medication Administration Record (MAR) medications were given then proceeded and administer R6's medications.	02320			

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02320	Continued From page 75 R1 R1's diagnoses included Alzheimer's. R1 Medication Management Plan: Addendum to Service Plan dated August 2, 2022, indicated R1 received medication administration and was able to self-administer after set-up. On May 24, 2023, at 7:22 a.m., the surveyor observed ULP-C prepare the following medications for R1 for self-administration: -torsemide 20 mg one (1) tablet (used to treat edema); -propylthiouracil 50 mg two (2) tablets (used to treat high thyroid levels); -mirtazapine 15 mg one (1) tablet (antidepressant); -Eliquis 5 mg one (1) tablet (blood thinner); and -acetaminophen 325 mg two (2) tablets (pain reliever). ULP-C initialed R1's MAR after placing medications into the medication cup, and then left R1's medications in R1's room to self-administer. ULP-C stated she doesn't always go back and check to ensure R1 took all of her medications because R1 took them on her own time. ULP-C stated one time she found a medication cup full of acetaminophen in R1's room and questioned R1 of why she wasn't taking the acetaminophen and stated R1 replied she takes them when she needs them. ULP-C stated she did not remove the acetaminophen from R1's room. R7, R8, R9 R7's Medication Management Plan: Addendum to Service Plan dated February 8, 2022, indicated R7 received medication administration; however, did not indicate R7 was able to self-administer medications after set up.	02320			

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02320	Continued From page 76 R8's Medication Management Plan: Addendum to Service Plan undated, indicated R8 received medication administration and was only able to self-administer albuterol sulfate inhaler (used to treat wheezing and shortness of breath) after set up. R9's Medication Management Plans: Addendum to Service Plan dated March 9, 2023, indicated R9 received medication administration; however, did not indicate R9 was able to self-administer medications after set up. On May 24, 2023, from 8:02 a.m., to 8:06 a.m., the surveyor observed ULP-C bringing R7, R8, and R9 a cup of medications and left with the residents at the breakfast table and walked away. ULP-C did not observe residents take their medications. On May 24, 2023, at 12:24 p.m., registered nurse/licensed assisted living director in residency (RN/LALDIR)-A stated staff were expected to document the administration of medications after the medications were administered to the residents and not prior to administration. RN/LALDIR-A further stated, unless the resident's medication plan indicated the resident was able to self-administer medications after set up, staff were expected to observed the resident take all of their medications. MEDICATION SET UP: R5 During entrance conference on May 23, 2023, at 10:08 a.m., RN/LALDIR-A stated the ULPs only set up resident's medications ahead of time for unplanned time away when the nurse was not available.	02320			

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02320	Continued From page 77 R5's diagnoses included glaucoma, atrial fibrillation (irregular heart beat), chronic kidney disease. R5's Medication Management Plan: Addendum to Service Plan dated May 23, 2023, indicated R5 received medication management. On May 24, 2023, at 7:02 a.m., the surveyor observed ULP-C obtained a medication cup of R5's morning medications from the top drawer of the medication cart and administer R5's medications. ULP-C stated she if she had time she would set up resident medications in the morning to administer at later time to make the morning medication pass easier since she administered all of the residents morning medications before her shift was done around 8:00 a.m. ULP-C's employee record indicated ULP-C was trained and competency tested by an RN in medication administration on April 5, 2023. On May 24, 2023, at 12:24 p.m., RN/LALDIR-A stated staff should not be setting up resident medication to administer at a later time. Medication should be prepared and immediately administer to the resident. The licensee's unsRWS Medication Protocol for Oral Medications policy, indicated to watch the resident swallow the medication. The licensee's undated Medication Administration for the Home Health Aide policy, indicated the following -document the medication administration immediately after giving the medication; -ensure the medications were consumed; and	02320		

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02320	Continued From page 78 -unless specific approval to leave the medication for the resident to take later, verify the resident takes the medication before documented administered. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320			



Minnesota Department of Health
Minnesota Department of Health
PO Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: 05/23/23
Time: 10:30:00
Report: 8010231081

Food and Beverage Establishment Inspection Report

Page 1

Location:

Scandia Capital Partners Llc
126 98th Avenue West
Duluth, MN55808
St. Louis County, 69

Establishment Info:

ID #: 0039239
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 6513351586
ID #:

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

The following orders were issued during this inspection.

4-700 Sanitizing Equipment and Utensils

4-702.11 ** Priority 1 **

MN Rule 4626.0900 Sanitize utensils and food contact surfaces of equipment before use, after cleaning.
THE DISHWASHER WAS NOT WORKING AND DISHES AND UTENSILS WERE NOT BEING
SANITIZED. A BUCKET WITH 100 PPM OF CHLORINE WAS SET UP TO SANITIZE DISHES AND
UTENSILS UNTIL THE NEW DISHWASHER IS INSTALLED.
MANUAL PROCEDURE IS: WASH, RINSE, SANITIZE AND AIR DRY
Corrected on Site

3-300C Protection from Contamination: equipment/utensils, consumers

3-305.11A

MN Rule 4626.0300A Store all food in a clean, dry location; where it is not exposed to splash, dust or other
contamination; and at least 6 inches above the floor.
BAGS OF POTATOES WERE STORED ON THE FLOOR IN THE STORAGE ROOM IN THE KITCHEN.
POTATOES WERE MOVED TO A SHELF.
Corrected on Site

Surface and Equipment Sanitizers

Chlorine: = 100 PPM at Degrees Fahrenheit
Location: SANITIZING BUCKET
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Upright Cooler
Temperature: 38 Degrees Fahrenheit - Location: MILK-KENMORE KITCHEN
Violation Issued: No

Type: Full
Date: 05/23/23
Time: 10:30:00
Report: 8010231081
Scandia Capital Partners Llc

Food and Beverage Establishment Inspection Report

Page 2

Process/Item: Upright Freezer
Temperature: Degrees Fahrenheit - Location: FOODS FROZEN-KENMORE BOTTOM KITCHEN
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 36 Degrees Fahrenheit - Location: CANTALOUPE-KENMORE BACK ROOM
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 38 Degrees Fahrenheit - Location: MILK-KENMORE BACK ROOM
Violation Issued: No

Process/Item: Upright Freezer
Temperature: Degrees Fahrenheit - Location: FOODS FROZEN-KENMORE BACK ROOM
Violation Issued: No

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

COMMENTS:

DISCUSSED THE EXCLUSION OF EMPLOYEES ILL WITH VOMITING OR DIARRHEA FROM THE FOOD ESTABLISHMENT FOR 24 HOURS AFTER SYMPTOMS ARE GONE.

ESTABLISHMENT IS USING PASTEURIZED EGGS.

FOOD IS PREPARED FOR SAME DAY SERVICE. NO LEFTOVER FOODS ARE SERVED TO THE RESIDENTS.

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 8010231081 of 05/23/23.

Certified Food Protection Manager Samantha Tabert

Certification Number: FM74713 Expires: 08/23/23

Inspection report reviewed with person in charge and emailed.

Signed: _____
Tawyni Huffman

Signed: _____
8010

651-201-4500
health.foodlodging@state.mn.us

Report #: 8010231081

DEPARTMENT OF HEALTH

Minnesota Department of Health

Minnesota Department of Health

PO Box 64975

St. Paul, MN 55164-0975

No. of RF/PHI Categories Out

1

Date

05/23/23

No. of Repeat RF/PHI Categories Out

0

Time In

10:30:00

Legal Authority MN Rules Chapter 4626

Time Out

Scandia Capital Partners Llc

Address

126 98th Avenue West

City/State

Duluth, MN

Zip Code

55808

Telephone

6513351586

License/Permit #

0039239

Permit Holder

Purpose of Inspection

Full

Est Type

Risk Category

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item

Mark "X" in appropriate box for COS and/or R

IN=in compliance

OUT= not in compliance

N/O= not observed

N/A= not applicable

COS=corrected on-site during inspection

R= repeat violation

Compliance Status

COS

R

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

X

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 compliance

Mark "X" in appropriate box for COS and/or R

COS=corrected on-site during inspection

R= repeat violation

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

X

Contamination prevented during food prep, storage & display

X

40

Personal cleanliness

41

Wiping cloths: properly used & stored

42

Washing fruits & vegetables

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

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:

05/26/23

Inspector (Signature)