Electronically Delivered

January 15, 2025

Licensee
Hope Wellness Center Inc.
3119 4th Avenue South
Minneapolis, MN 55408

RE: Project Number(s) SL36235015

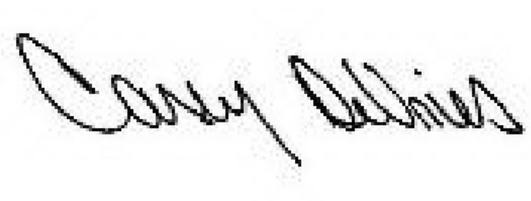
Dear Licensee:

On December 31, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the August 16, 2024, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,



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

JMD

Electronically Delivered

September 26, 2024

Licensee
Hope Wellness Center Inc.
3119 4th Avenue South
Minneapolis, MN 55408

RE: Project Number(s) SL36235015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 16, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility**.

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

The correction order documentation should include the following:

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

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

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

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

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

If you have any questions, please contact me.

Sincerely,

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

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36235	A. BUILDING: _____ B. WING _____	08/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPE WELLNESS CENTER INC	3119 4TH AVENUE SOUTH MINNEAPOLIS, MN 55408

(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: SL36235015-0 On August 12, 2024, through August 16, 2024, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were two residents receiving services under the Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 650 SS=F	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of	0 650		

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0 650	Continued From page 1 each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the employee record contained the required content for orientation and training; and failed to ensure the registered nurse (RN) documented competency evaluations as required for two of two unlicensed personnel ((ULP)-A, ULP-B). 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	0 650		

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0 650	Continued From page 2 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: ULP-A ULP-A was hired January 9, 2022. On August 13, 2024, at 9:00 a.m., the surveyor observed ULP-A assist R2 with medication administration. ULP-A's personnel record lacked documentation of the required assisted living orientation as followed: - overview of Assisted Living statutes; - review of provider's policies and procedures; - reporting maltreatment of vulnerable adults or minors; - handling of resident complaints; - consumer advocacy services; - review of the type of assisted living services the employee will provide; - principle of person-centered planning/service delivery; - handling emergencies and using emergency services; and - review of the assisted living bill of rights. On August 12, 2024, at 12:32 p.m., the surveyor verified ULP-A was not listed on the Minnesota Nurse Aide Registry (NAR). ULP-A's personnel record lacked documentation of the following training for unlicensed personnel not found on NAR as followed: - documentation requirements for all services provided; - reports of changes in the resident's condition to	0 650		

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0 650	Continued From page 3 the supervisor designated by the facility; - basic infection control, including blood-borne pathogens; - maintenance of a clean and safe environment; - prevention of falls; - medication, exercise, and treatment reminders; - basic nutrition, meal preparation, food safety, and assistance with eating; - preparation of modified diets as ordered by a licensed health professional; - communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; - awareness of confidentiality and privacy; - procedures to use in handling various emergency situations; - awareness of commonly used health technology equipment and assistive devices; - observing, reporting, and documenting resident status; - basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; - recognizing physical, emotional, cognitive, and developmental needs of the resident; - hair care and bathing; - care of teeth, gums, and oral prosthetic devices; - care and use of hearing aids; - dressing and assisting with toileting; - standby assistance techniques and how to perform them; - reading and recording temperature, pulse, and respirations of the resident; - safe transfer techniques and ambulation; - range of motioning and positioning; - administering medications or treatments as required; and - blood glucose.	0 650		

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0 650	Continued From page 4 On August 13, 2024, at 9:10 a.m., ULP-A stated they were trained by RN-F who had shown ULP-A how to perform blood glucose testing and ULP-A returned demonstration the next day. On August 16, 2024, at 10:21 a.m., ULP-A stated RN-F and another nurse (who had not worked for the licensee for a while) had completed training and competency on all medication routes and completed the training and competencies for unlicensed personnel. On August 16, 2024, at 11:02 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated ULP-A had completed the training for orientation, however the licensee misplaced the documentation. LALD/CNS-C stated some of the trainings were completed by use of Care Providers Paperwork (common education provider). ULP-B ULP-B was hired July 11, 2024. On August 12, 2024, at 2:33 p.m., the surveyor verified ULP-B was not listed on the Minnesota Nurse Aide Registry (NAR). ULP-B's personnel record lacked documentation of the following training for unlicensed personnel not found on NAR as followed: - documentation requirements for all services provided; - reports of changes in the resident's condition to the supervisor designated by the facility; - basic infection control, including blood-borne pathogens; - maintenance of a clean and safe environment; - prevention of falls;	0 650		

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0 650	Continued From page 5 - medication, exercise, and treatment reminders; - basic nutrition, meal preparation, food safety, and assistance with eating; - preparation of modified diets as ordered by a licensed health professional; - understanding appropriate boundaries between staff and residents and the resident's family; - procedures to use in handling various emergency situations; - awareness of commonly used health technology equipment and assistive devices; - observing, reporting, and documenting resident status; - basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; - recognizing physical, emotional, cognitive, and developmental needs of the resident; - hair care and bathing; - care of teeth, gums, and oral prosthetic devices; - care and use of hearing aids; - dressing and assisting with toileting; - standby assistance techniques and how to perform them; - reading and recording temperature, pulse, and respirations of the resident; - safe transfer techniques and ambulation; - range of motioning and positioning; - administering medications or treatments as required; and - blood glucose. On August 16, 2024, at 10:02 a.m., ULP-B stated they had completed their training with RN-F and agent/manager (AM)-D and then shadowed ULP-A. ULP-B stated RN-F had performed the training and competencies for core education, medications for all routes and blood glucose by going over the details and the process. Also,	0 650		

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0 650	Continued From page 6 ULP-B stated both AM-D and RN-F have seen them provide cares to the residents plenty of times. On August 12, 2024, at 10:15 a.m., during the entrance conference, LALD/CNS-C stated they were aware of the required contents of the employee records. On August 12, 2024, at 2:02 p.m., AM-D stated all employees should have the annual training completed on their hire dates. AM-D stated the nurse or manager would put the education needed in Educare (common education website), notify staff, and then the nurse or manager is to review for completion. Also, AM-D stated the licensee had used Care Provider prior to Educare and would check to see it these were filed away. On August 12, 2024, at 2:38 p.m., LALD/CNS-C stated the licensee did not have any other education on file. On August 14, 2024, at 3:05 p.m., RN-F stated they trained staff on all routes of medications but did not document the competency for the personnel records. On August 16, 2024, at 11:17 a.m., LALD/CNS-C stated all the core trainings and competencies were done previously for ULP-A and ULP-B, however the paperwork was misplaced for all of these. The licensee's Personnel Records policy dated 2021, indicated all documents related to orientation, annual training, infection control training, and competency evaluations would be kept in the personnel record.	0 650		

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0 650	Continued From page 7 No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included TB baseline screening for one of two unlicensed personnel ((ULP)-A). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an	0 660		

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0 660	Continued From page 8 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: The licensee's Facility TB Risk Assessment dated August 1, 2024, identified the facility was at a low risk for TB transmission. ULP-A was hired on January 9, 2022. ULP-A's record included a Baseline TB Screening Tool for Healthcare Workers (HCWs) form dated July 1, 2022, which indicated, Baseline TB screening includes two components: (1) Assessing for current symptoms and (2) Testing for the presence of infection with mycobacterium tuberculosis by administering either a single TB blood test or a two-step test. The Symptoms of Active TB Disease section was blank and did not have a signature or date by the licensee to indicate this section was reviewed. Also, the Baseline TB Screening Tool for Healthcare Workers (HCWs) was not completed upon hire. ULP-A's record included testing results of TB QuantiFERON Gold Plus NIL that was collected on February 14, 2023. ULP-A's record lacked documentation of baseline TB testing results upon hire or within 90 days of date of hire. On August 16, 2024, at 10:50 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated they are aware of the TB process at hire, but they did not know why the TB screening and testing were not done at hire. The licensee's 8.16 Tuberculosis Screening	0 660		

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0 660	Continued From page 9 policy dated May 1, 2024, indicated the licensee would complete staff screening for those whose essential job functions require work within the same air space of clients and Baseline screening will be completed upon hire. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule.	0 680		

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0 680	Continued From page 10 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a written emergency preparedness plan (EPP) with all the required content as defined in Appendix Z. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: The licensee's undated EPP lacked evidence of the following required content: - process for EPP collaboration; - subsistence needs for staff and patients; - procedure for tracking of staff and patients; - policies and procedures for medical documents; - policies and procedures for volunteers; - arrangement with other facilities; - roles under a wavier declared by secretary; - development of communication plan; - names and contact information; - primary/alternate means for communication; - methods for sharing information; - sharing information on occupancy/needs; - LTC (long term care) family notifications; - emergency prep training and testing; - emergency prep training program; and - emergency prep testing requirements. On August 13, 2024, at 8:50 a.m., agent/manager	0 680		

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0 680	Continued From page 11 (AM)-D acknowledged the EPP was not complete. AM-D stated the licensee did not have any written agreements with other facilities or places if they had to evacuate the residents and did not have emergency supplies at the facility if they had to shelter in place. AM-D stated they would work on getting the EPP in compliance as defined in Appendix Z as it was an oversight. The licensee's 9.01 Emergency Preparedness Plan - Appendix Z Compliance policy dated May 1, 2024, indicated the licensee would have in place an emergency preparedness plan, that is in alignment with facility's requirement to also comply with CMS (Centers for Medicare and Medicaid Services) Appendix Z. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 780 SS=D	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics;	0 780		

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HOPE WELLNESS CENTER INC	3119 4TH AVENUE SOUTH MINNEAPOLIS, MN 55408

(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
0 780	Continued From page 12 (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide interconnected smoke alarms in all sleeping rooms in the facility. This had the potential to directly affect a limited number of 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 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: During facility tour on August 13, 2024, from 11:15 a.m. through 11:45 a.m. with office coordinator (OC)-E, the surveyor observed that the smoke alarm in sleeping room 4, located in the basement, was not interconnected so activation of one alarm activates all alarms in the facility. All dwelling units required to have multiple smoke	0 780		

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0 780	Continued From page 13 alarms are required to have interconnected alarms so activation of one alarm activates all alarms within the dwelling unit. During the tour OC-E tested the smoke alarms and verified the smoke alarm in sleeping room 4 was not interconnected so activation of one alarm activates all alarms throughout the facility. OC-E stated they would install a new smoke alarm in sleeping room 4 so that it was connected with all other alarms in the facility. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in	0 810		

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0 810	Continued From page 14 their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and failed to conduct the required training. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On August 13, 2024, at 11:50 a.m., office coordinator (OC)-E, provided documentation on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN	0 810		

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0 810	Continued From page 15 The licensee's FSEP, titled "9.06 Fire Policy", dated 5/1/24, failed to include the following: The FSEP did not include an evacuation map with a floor plan accurate to the building layout that showed the location and number of resident sleeping rooms. The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan was designed for a building with life safety systems such as manual fire alarms, automatic dialing to the fire department, smoke doors, fire doors, and fire sprinklers. The policy had not been updated to provide complete actions for employees to take in the event of a fire or similar emergency at the licensed facility which did not have life safety systems stated in the policy. During an interview on August 13, 2024, at 12:10 p.m., OC-E stated that they understood the requirement and would update the FSEP and include the evacuation maps. TRAINING Record review indicated the licensee failed to provide evacuation training based on the fire safety and evacuation plan to residents, at least once per year as evident by not providing documentation of training offered or training scheduled for a future date. Record review indicated the licensee failed to provide evacuation training based on the fire safety and evacuation plan to employees, at hire	0 810		

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0 810	Continued From page 16 and twice per year as evident by not providing documentation of training offered or training scheduled for a future date. During an interview on August 13, 2024, at 12:10 p.m., OC-E stated that they use Educare for employee training. The surveyor explained that this training includes basic fire safety but does not include training specific to this facility and site for fire safety and evacuation. The surveyor explained the requirements for training staff at hire and twice annually and annually offering training to residents on the FSEP. OC-E stated they understood the requirement. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
0 950 SS=C	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of	0 950		

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0 950	Continued From page 17 attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract included the designation of representative statutory language notice for two of two residents (R1, R2). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: R1 R1 was admitted on June 5, 2024. R1's Resident Contract for Assisted Living dated June 6, 2024, had a section for resident to designate a representative or decline to name a representative, however this section was blank. R1's Resident Contract for Assisted Living lacked the verbatim designated representative statutory	0 950		

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0 950	Continued From page 18 language notice. R2 R2 was admitted on October 13, 2020. R2's [Licensee] Assisted Living Contract dated October 13, 2021, lacked a section for the resident to designate a representative or decline to name a representative and the verbatim designated representative statutory language notice. On August 13, 2024, at 11:52 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated the separate page of the contract that included the designation of representative statutory language notice must have been missed with the printing of the contract and stated the licensee would complete the designated representative with residents. The licensee's 1.08 Designated Representative policy dated May 1, 2024, indicated the licensee would give residents the opportunity to identify a designated representative in writing prior to, or at the time of execution of an assisted living contract. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 950		
01460 SS=D	144G.63 Subdivision 1 Orientation of staff and supervisors All staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations	01460		

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01460	Continued From page 19 before providing assisted living services to residents. The orientation may be incorporated into the training required under subdivision 5. The orientation need only be completed once for each staff person and is not transferable to another facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employees received orientation to assisted living facility licensing requirements and regulations with all required content for one of two unlicensed personnel ((ULP)-B). 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-B ULP-B was hired July 11, 2024. On August 16, 2024, at 10:53 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated ULP-B had a background study completed on July 3, 2024, and then began to provide cares to residents on July 11, 2024. ULP-B's employee record lacked evidence the employee completed orientation to assisting living facility requirements to include:	01460		

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01460	Continued From page 20 - overview of Assisted Living statutes; - review of provider's policies and procedures; - handling emergencies and using emergency services; - reporting maltreatment of vulnerable adults or minors; - review of the assisted living bill of rights; - handling of resident complaints; - consumer advocacy services; - review of the type of assisted living services the employee will provide; and - principle of person-centered planning/service delivery. ULP-B's undated transcript included required orientation course for assisted living Bill of Rights, however this was completed April 20, 2024, prior to ULP-B's hire date. On August 12, 2024, at 2:38 p.m., agent/manager (AM)-D stated ULP-B had their training records transferred from another licensee. On August 13, 2024, at 1:49 p.m., LALD/CNS-C stated they were not aware orientation training could not be transferred from another licensee. On August 16, 2024, at 11:05 a.m., LALD/CNS-C stated ULP-B's orientation training was completed verbally or by the old system for Care Providers (common education program) and in Educare (common education website) however the licensee had missed placed documentation of the training within the last month. After receiving conflicting interviews during the course of the survey, it was unclear to the surveyor if the orientation was completed or not. The licensee's 5.01 Orientation of Staff and	01460		

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01460	Continued From page 21 Supervisors & Content policy, dated May 1, 2024, indicated all staff providing assisted living services must complete an orientation to assisted living requirements and regulations before providing services to residents. The policy listed topics for orientation, which included those identified above. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01460		
01490 SS=D	144G.63 Subd. 4 Training required relating to dementia All direct care staff and supervisors providing direct services must demonstrate an understanding of the training specified in section 144G.64. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure required dementia care training was completed within 160 working hours of the employment start date for one of two unlicensed personnel ((ULP)-A). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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).	01490		

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01490	Continued From page 22 The findings include: ULP-A was hired January 9, 2022. On August 13, 2024, at 9:00 a.m., the surveyor observed ULP-A assist R2 with medication administration. ULP-A's transcript printed on August 12, 2024, indicated ULP-A was assigned the following dementia education on January 8, 2022, but was not completed within 160 working hours of employment start date: - Person-Centered Care completed May 16, 2024; - Problem Solving - Anger and Aggression completed May 16, 2024; - Problem Solving - Anxiety completed on May 16, 2024; - Introduction and Overview completed on May 16, 2024; - Communication - completed on May 17, 2023; - Activities of Daily Living completed on May 17, 2023; - Behaviors vs Symptoms completed on May 21, 2024; - The Journey completed on May 21, 2024; and - Management and Abuse Prevention completed on May 17, 2023. On August 12, 2024, at 2:38 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated ULP-A started to provide cares to residents on January 9, 2022, and had worked more than 160 hours since employment started as ULP-A worked forty hours per week. On August 16, at 11:01 a.m., LALD/CNS-C stated the nurse or manager would assign education in Educare (common education website) and then	01490		

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01490	Continued From page 23 notify staff to complete. The nurse or manager would verify if these were completed, however this must have been an oversight. The licensee's 5.03 Dementia Training policy, dated May 1, 2024, indicated direct care employees would need to complete at least eight hours of initial education within 160 hours of employment start date in the following required topics: - an explanation of Alzheimer's disease and other dementias; - assistance with activities of daily living; - problem solving with challenging behaviors; - communication skills; and - person centered planning and service delivery. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01490		
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	01500		

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01500	Continued From page 24 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 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	01500		

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01500	Continued From page 25 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 annual training included all required topics for each 12 months of employment, for one of one unlicensed personnel ((ULP)-A). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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-A was hired January 9, 2022. On August 13, 2024, at 9:00 a.m., the surveyor observed ULP-A assist R2 with medication administration. ULP-A's employee record lacked evidence of the following required topics of annual training in 2023: - reporting maltreatment of vulnerable adults or minors; - assisted Living Bill of Rights; - infection control techniques; - effective approaches to use to problems solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders;	01500		

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01500	Continued From page 26 - review of provider's policies and procedures; and - principles of person-centered planning/service delivery ULP-A's employee record lacked evidence of the following required topics of annual training in 2024: - reporting maltreatment of vulnerable adults or minors; and - review of provider's policies and procedures. On August 12, 2024, at 2:02 p.m., agent/manager (AM)-D stated all employees should have the annual training completed on their hire dates. AM-D stated the nurse or manager would put the education needed in Educare (common education website), notify staff, and then the nurse or manager was to review for completion. Also, AM-D stated the licensee had used Care Provider (common education provider) prior to Educare and would check to see it these were filed away. On August 12, 2024, at 2:38 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated the licensee did not have any other education on file. On August 16, at 11:01 a.m., LALD/CNS-C stated the nurse or manager would assign education in Educare (common education website) and then notify staff to complete. The nurse or manager would verify if these were completed, however this must have been an oversight. The licensee's 5.06 Annual Required Staff Training policy dated August 1, 2021, indicated all staff who provided direct care would complete eight hours of annual training and would include	01500		

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01500	Continued From page 27 the training elements as required by statue. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		
01560 SS=D	144G.64 (a, b, c) TRAINING IN DEMENTIA CARE REQUIRED (5) new employees may satisfy the initial training requirements by producing written proof of previously completed required training within the past 18 months. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and other dementias; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; (4) communication skills; and (5) person-centered planning and service delivery. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure required dementia care training was completed for all required topics for one of two unlicensed personnel ((ULP)-B). 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	01560		

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01560	Continued From page 28 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-B was hired July 11, 2024. ULP-B's transcript included the following dementia care trainings: - an explanation of Alzheimer's disease and other dementias; - communication skills; - behaviors vs symptoms; and - the journey. ULP-B records lacked evidence of dementia care training in the following areas: - assistance with activities of daily living; - problem solving with challenging behaviors; and - person-centered planning and service delivery. On August 12, 2024, at 2:53 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated ULP-B had worked a total of 218 hours since the employment start date. On August 16, at 11:01 a.m., LALD/CNS-C stated the nurse or manager would assign education in Educare (common education website) and then notify staff to complete. The nurse or manager would verify if these were completed, however this must have been an oversight. The licensee's 5.03 Dementia Training policy dated May 1, 2024, indicated direct care employees would need to complete at least eight hours of initial education within 160 hours of	01560		

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01560	Continued From page 29 employment start date in the following required topics: - an explanation of Alzheimer's disease and other dementias; - assistance with activities of daily living; - problem solving with challenging behaviors; - communication skills; and - person centered planning and service delivery. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01560		
01610 SS=D	144G.70 Subd. 2 (a-b) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan 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. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	01610		

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01610	Continued From page 30 review, the licensee failed to ensure the registered nurse (RN) completed an initial assessment prior to the date on which a prospective resident executed a contract with a facility or on the day the resident moved in for one of two residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On August 14, 2024, at 1:32 p.m., the surveyor observed agent/manager (AM)-D assist R1 with medication administration. R1 was admitted to the licensee on June 5, 2024. R1's Resident Contract for Assisted Living was signed on June 5, 2024. R1's Service Plan dated June 7, 2024, indicated R1 received assistance with bathing, dressing, appointments, housekeeping, incontinence care, behavior management, meal assistance, medication administration, and blood glucose monitoring. R1's Assessment dated June 7, 2024, indicated the assessment was a pre-admission assessment. The assessment was completed two days after R1's admission to the licensee. R1's record lacked an admission assessment.	01610		

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01610	Continued From page 31 On August 16, 2024, at 11:18 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated R1 moved in on June 5, 2024, but the assessment was not completed until June 7, 2024, due to R1 refusing the assessment since she was previously homeless and had been tired. On August 16, 2024, at 12:55 p.m., the surveyor received an email from AM-D and indicated R1's record did not have a note of R1 refusing assessment on June 5, 2024. AM-D indicated R1 had moved in quickly since they were previously homeless, and the nurse came to do the assessment as soon as she could. On August 16, 2024, LALD/CNS-C stated R1 did not have a temporary service plan prior to June 7, 2024. The licensee's 6.01 Assessments, Reviews & Monitoring policy dated May 1, 2024, indicated [licensee] would conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident 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. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01610		
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan	01730		

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01730	Continued From page 32 (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 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	01730		

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01730	Continued From page 33 medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop an individualized medication management plan with the required content for one of two residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was admitted to the licensee on June 5, 2024, with diagnoses of bipolar disorder and diabetes. R1's Service Plan dated June 7, 2024, indicated R1 received assistance with bathing, dressing, appointments, housekeeping, incontinence care, behavior management, meal assistance, medication administration, and blood glucose monitoring. On August 14, 2024, at 1:32 p.m., the surveyor observed agent/manager (AM)-D give R1 Lantus Solostar insulin pen and Victoza pen with disposable needles. The surveyor observed R1 place the needles on each pen and administer Lantus without priming the insulin pen and administer Victoza without preparing the pen prior to administration. Also, the surveyor observed both medications were administered adjacent to	01730		

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01730	Continued From page 34 each other on the right side of abdomen. R1's Individualized Medication Management Plan (IMMP) dated July 9, 2024, indicated R1 self-administered insulin after it was handed to R1 and medication management tasks that may be delegated to unlicensed personnel included oral medications only. R1's IMMP lacked specific instructions for priming of the insulin pen and preparing Victoza. R1's Med Admin Summary dated August 2024, included Lantus Solostar 100 units(u)/milliliter (ml) injection, Client to self-administer insulin 40 u once a day and Victoza 18 milligram (mg)/3ml injection, inject 1.8 mg subcutaneously once daily. On August 14, 2024, at 1:39 p.m., R1 stated they have never primed or prepared the pens before they administered the medications. On August 14, 2024, at 2:18 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated they did not provide the teaching to the unlicensed staff as this was done by a previous nurse and prior to LALD/CNS-C's hire date. LALD/CNS-C stated ULPs should put the needles on the pens, prime and set the dose prior to giving the pens to the resident for administration. On August 14, 2024, at 2:23 p.m., agent/manager (AM)-D stated they have never been instructed to prime or prepare the pens prior to giving to R1 for administration. The manufacturer's instructions for the use of Victoza pens dated June 2023, directed for the pen to be prepared as followed: point pen with	01730		

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01730	Continued From page 35 needle up, tap the cartridge gently with finger a few times to bring any air bubbles to the top, press dose button until 0 mg lines up with pointer, may repeat up to 6 times until a drop of Victoza appears at the needle tip. Also, the manufacturer's instructions included important administration instructions for using Victoza with other insulins that included it was acceptable to inject Victoza and insulin in the same body region, but the injections should not be adjacent to each other. The manufacturer's instructions for the use of Lantus Solostar insulin pens dated November 2023, directed for the insulin pen to be primed with two units prior to dialing the prescribed dosage and, if not completed before each injection, too much or too little insulin may be administered. The licensee's 7.15 Medications & Treatment - Administration & Delegation policy dated May 1, 2024, indicated a registered nurse (RN) must conduct a face-to-face resident assessment to determine what medication management services would be provided and how those services would be provided by written specific instructions for each resident and documented instructions in the residents' record. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01790 SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy	01790		

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01790	Continued From page 36 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 medications were provided and who received the medications, the person who provided the	01790		

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01790	Continued From page 37 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 observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) documented training and competencies for two of two unlicensed personnel ((ULP)-A, ULP-B) who would provide medications for residents with unplanned time away from home when a licensed nurse was not available. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include:	01790		

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01790	Continued From page 38 ULP-A ULP-A was hired January 9, 2022. On August 13, 2024, at 9:00 a.m., the surveyor observed ULP-A assist R2 with medication administration. ULP-A's personnel record lacked documentation ULP-A was trained and found competent at this facility to provide medications to residents who had unplanned times away. On August 16, 2024, at 10:21 a.m., ULP-A stated they would call the nurse right away to pack medications if a resident said they were leaving the home and for an unplanned time away, ULP-A would tell the resident to wait. ULP-A stated they were trained and that was how they knew they could not pack the medications without telling the nurse. ULP-B ULP-B was hired July 11, 2024. ULP-B's personnel record lacked documentation ULP-B was trained and found competent at this facility to provide medications to residents who had unplanned times away. On August 16, 2024, at 10:00 a.m., ULP-B stated agent/manager (AM)-D would pack medications for unplanned times away and reported AM-D had trained ULP-B, but they had not performed this task yet. On August 13, 2024, at 11:17 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated they had not provided any training on unplanned times away as they were	01790		

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01790	Continued From page 39 recently just hired. LALD/CNS-C stated they would complete the training and competencies. On August 16, 2024, at 11:14 a.m., LALD/CNS-C stated the training was completed by the previous nurse but the papers were misplaced. After receiving conflicting interviews during the course of the survey, it was unclear to the surveyor if the training and competenies were completed or not. The licensee's Medication Management Plan for Residents Away from Home dated August 1, 2021, indicated unlicensed personnel would be trained and deemed competent by a registered nurse prior to performing the task. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01790		
02290 SS=F	144G.91 Subd. 2 Legislative intent The rights established under this section for the benefit of residents do not limit any other rights available under law. No facility may request or require that any resident waive any of these rights at any time for any reason, including as a condition of admission to the facility. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee limited the rights of residents when the licensee required residents to sign and follow house rules for two of three residents (R2, R3).	02290		

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02290	Continued From page 40 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: R2 was admitted on October 13, 2020. R2's House Rules dated August 23, 2021, indicated the following: - The facility is a no drug use facility. No drugs or alcohol are allowed on the premises or surrounding areas of the property at any time. Suspicion of drug abuse use is reportable to law enforcement and will be considered a gross violation. - If residents leave the home unattended, residents' bags will be searched, and pockets will need to be emptied. If resident refuses, police will be called. - Failure to comply with any of the above would be considered violation to the house rules/policies/procedures may be subject to termination of services and lease agreement. R3 was admitted on December 16, 2023. R3's House Rules dated December 16, 2023, indicated the following: - The facility is a no drug use facility. No drugs or alcohol are allowed on the premises or surrounding areas of the property at any time. Suspicion of drug abuse use is reportable to law enforcement and will be considered a gross	02290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36235	A. BUILDING: _____ B. WING _____	08/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPE WELLNESS CENTER INC	3119 4TH AVENUE SOUTH MINNEAPOLIS, MN 55408

(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
02290	Continued From page 41 violation. - If residents leave the home unattended, residents' bags will be searched, and pockets will need to be emptied. If resident refuses, police will be called. - Failure to comply with any of the above would be considered violation to the house rules/policies/procedures may be subject to termination of services and lease agreement. On August 13, 2024, at 8:05 a.m., the surveyor observed R2 request ULP-A go on the back deck with R2. On August 13, 2024, at 2:13 p.m., agent/manager (AM)-D stated R1 had not had the chance to sign the house rules yet. On August 14, 2024, at 10:29 a.m., the surveyor observed R2 verifying with staff if they were ok to go outside with the surveyor. On August 14, 2024, at 10:30 a.m., during an interview, R2 stated the staff have often grabbed at them to check for items such as drugs and gave example of checking pockets if they leave the facility without staff. On August 16, 2024, at 10:21 a.m., unlicensed personnel (ULP)-A stated they had to search resident's pockets and bags when the resident returned to the facility due to house rules. On August 16, 2024, at 2:15 p.m., AM-D stated they had not had to terminate a resident due to house rules, however they were working with R2's case manager to get her into treatment. On August 16, 2024, at 11:27 a.m., licensed assisted living director/clinical nurse supervisor	02290		

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	36235	A. BUILDING: _____ B. WING _____	08/16/2024

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02290	Continued From page 42 (LALD/CNS)-C stated they would notify the residents case manager and the provider if a resident had refused to be searched as they had the right to refuse. LALD/CNS-C stated they were not aware of any situations where a resident was searched. The licensee's 2.30 Protecting Resident Rights policy dated May 1, 2024, indicated licensee would protect the rights of their residents and would not request or require residents to waive any of the rights provided at any time for any reason. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02290		
02400 SS=C	144G.91 Subd. 12 Visitors and social participation (a) Residents have the right to meet with or receive visits at any time by the resident's family, guardian, conservator, health care agent, attorney, advocate, or religious or social work counselor, or any person of the resident's choosing. This right may be restricted in certain circumstances if necessary for the resident's health and safety and if documented in the resident's service plan. (b) Residents have the right to engage in community life and in activities of their choice. This includes the right to participate in commercial, religious, social, community, and political activities without interference and at their discretion if the activities do not infringe on the rights of other residents.	02400		

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02400	Continued From page 43 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to respect the resident's right to receive visits at any time. This had the potential to affect all residents at the facility. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: On August 12, 2024, at 11:18 a.m., the surveyor observed a sign posted by the front door that read, no male visitors were allowed to come after 8:00 p.m. If they do arrive before this time, they must stay in the living room and no overnight guest were allowed for safety purposes. On August 12, 2024, at 11:22 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated the licensee had to put visitor restriction in place due to anxiety concerns of another resident. LALD/CNS-C stated they would remove the posting. R1 and R2's medical records lacked documentation of a health or safety concern for visitor restriction. The licensee's 2.30 Protecting Resident Rights policy dated May 1, 2024, indicated licensee would protect the rights of their residents and	02400		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36235	A. BUILDING: _____ B. WING _____	08/16/2024

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02400	Continued From page 44 would not request or require residents to waive any of the rights provided at any time for any reason. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02400		
02410 SS=D	144G.91 Subd. 13 Personal and treatment privacy (a) Residents have the right to consideration of their privacy, individuality, and cultural identity as related to their social, religious, and psychological well-being. Staff must respect the privacy of a resident's space by knocking on the door and seeking consent before entering, except in an emergency or unless otherwise documented in the resident's service plan. (b) Residents have the right to have and use a lockable door to the resident's unit. The facility shall provide locks on the resident's unit. Only a staff member with a specific need to enter the unit shall have keys. This right may be restricted in certain circumstances if necessary for a resident's health and safety and documented in the resident's service plan. (c) Residents have the right to respect and privacy regarding the resident's service plan. Case discussion, consultation, examination, and treatment are confidential and must be conducted discreetly. Privacy must be respected during toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance. This MN Requirement is not met as evidenced by:	02410		

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	36235	A. BUILDING: _____ B. WING _____	08/16/2024

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02410	Continued From page 45 Based on interview and record review, the licensee failed to ensure resident's right to consideration of their privacy and personal property was maintained for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 was admitted on October 13, 2020, with diagnoses of schizoaffective disorder (symptoms of schizophrenia and mood disorder), bipolar disorder (mood swings), personality disorder, and post-traumatic stress disorder. R2's Service Plan dated January 5, 2024, indicated R2 received assistance with activities, appointments, bathing, declutter room, dressing, grooming, housekeeping, laundry, behavior management, meal reminder, medication administration, medication set up, monitoring of vital signs, and shopping. The licensee's Incident Report dated July 25, 2024, indicated unlicensed personnel (ULP)-A notified registered nurse (RN)-F of concerns with R2 becoming more verbally aggressive. ULP-A had reported to RN-F that R2 had appeared to be using drugs the day prior and reported drugs were found from a room search. ULP-A notified RN-F that ULP-A believed R2 had more drugs in	02410		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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02410	Continued From page 46 her room but was declining a room search and became verbally abusive and threatened ULP-A when they attempted to complete a room search. R2's room was searched again upon arrival of licensee's manager and COPE (Hennepin County mobile crisis response) On August 14, 2024, at 10:30 a.m., during an interview, R2 stated over a year ago, two staff members had pulled them out of bed, pulled their pants down while a blanket was over their head, looking for drugs. R2 stated it was hard to breathe during this time. Also, R2 stated staff searched their room against their wishes. On August 13, 2024, at 1:09 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated they were not aware of R2's incident as this happened prior to their hire date. Also, LALD/CNS-C stated they were not aware of any current agreements to search resident rooms without the resident's permission. On August 13, 2024, at 1:10 p.m., agent/manager (AM)-D stated there were no agreements in place prior to that incident. AM-D stated they had reached out to The Office of Ombudsman for Long-Term Care and was told they could search rooms for drugs and alcohol if this affects the health and safety of other residents. On August 13, 2024, at 1:12 p.m., LALD/CNS-C stated the residents signed a contract that indicated this facility was a drug free and alcohol-free home. The licensee's 2.05 Bill of Rights policy dated May 1, 2024, indicated staff would be trained on the concepts/rights in the bill of rights.	02410		

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02410	Continued From page 47 The licensee's 2.30 Protecting Resident Rights policy dated May 1, 2024, indicated licensee would protect the rights of their residents and would not request or require residents to waive any of the rights provided at any time for any reason. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02410		

Minnesota Department of Health
Environmental Health, FPLS
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *08/12/24*
Time: 11:45:00
Report: 1039241243

Food and Beverage Establishment Inspection Report

Location:
Hope Wellness Center Inc
3119 4th Avenue South
Minneapolis, MN55408
Hennepin County, 27

Establishment Info:
ID #: 0038733
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 2067797540
ID #:

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

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

Utensil Surface Temp: = at >160 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: MILK
Temperature: 35 Degrees Fahrenheit - Location: COLD HOLD REFRIGERATOR
Violation Issued: No

Process/Item: FROZEN
Temperature: Degrees Fahrenheit - Location: FREEZER ON REFRIG.
Violation Issued: No

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

The inspection was completed with the person in charge and reviewed with MDH nurse evaluator Rhawnie Quinehan.

The kitchen is of residential build and should serve food for same-day service only.

The kitchen has wood cabinets with hollow base, laminate wood floor, painted walls and ceiling, faux-granite countertops. These kitchen finishes and surfaces are clean and well maintained.

The kitchen refrigerator/freezer are of residential grade.

A 2-compartment sink is present in kitchen. 1 compartment is designated for handwashing only.

Type: Full
Date: *08/12/24*
Time: 11:45:00
Report: 1039241243
Hope Wellness Center Inc

Food and Beverage Establishment Inspection Report

A residential NSF dishwashing machine is present in the kitchen. Per irreversible waterproof thermometer, the dish washing machine achieves a utensil surface temperature of >160 degrees F.

A supply of single-use gloves is present in kitchen. A thin-probe food thermometer is present in kitchen. A supply of single-use sanitizing wipes for food contact surfaces is present in kitchen.

Please note: A bleach solution can be prepared by mixing 1 tablespoon of bleach concentrate from bottle (unscented) with 1 gallon of water, then put into a labeled spray bottle for use as sanitizer as an alternative to disposable sanitizer wipes. The solution should be 50 to 200 ppm Chlorine. Use chlorine test strips to measure (google search: chlorine test strips 0 to 200 ppm)

Discussed the following with the person-in-charge: minimum cook temps for animal proteins, food source, foodborne illness symptoms and exclusion of ill employees, avoiding bare hand contact with ready to eat foods, handwashing, sanitizing, vomit clean-up procedures.

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 1039241243 of 08/12/24.

Certified Food Protection Manager: Samia Mahmud

Certification Number: FM121203 Expires: 08/02/23

Inspection report reviewed with person in charge and emailed.

Signed: _____

Samia Mahmud
person-in-charge

Signed: _____

Aron Goodner
Public Health Sanitarian I
Freeman Building
aron.goodner@state.mn.us