DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF REMOVAL OF CONDITIONAL LICENSE

Electronic Delivery

August 11, 2023

Licensee
Restful Home LLC
1000 Reaney Avenue
Saint Paul, MN 55106

RE: Initial License Number 408395
Health Facility Identification Number (HFID) 33425
Project Number(s) SL33425015

Dear Licensee:

On August 1, 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 April 5 , 2023. The follow-up survey found the facility to be in substantial compliance. **Based on these findings, the condition(s) on the license were removed effective August 8, 2023.**

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

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

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a), state correction orders issued pursuant to the last survey completed on April 5, 2023, found not corrected at the time of the follow-up survey follow-up survey and subject to a penalty assessment are as follows:

0480-Minimum Requirements-144g.41 Subd 1 (13) (i) (b) - $500.00
0660-Tuberculosis Prevention And Control-144g.42 Subd. 9

The details of the violations noted at the time of this follow-up survey completed on August 1, 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 $500.00**. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

IMPOSITION OF FINES:

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

CORRECTION ORDER RECONSIDERATION PROCESS
In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by 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/or state form with your organization's Governing Body.

Sincerely,

Lindsey L. Krueger, RN, BS, MA
Assistant Division Director

Minnesota Department of Health
Health Regulation Division

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33425	A. BUILDING: _____ B. WING _____	R 08/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RESTFUL HOME LLC	1000 REANEY AVENUE SAINT PAUL, MN 55106

(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 SL33425015-1 On August 1, 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 April 5, 2023. At the time of the survey, there were eight (8) residents receiving services under the Assisted Living license. As a result of the revisit, the following orders were reissued.	{0 000}	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living license providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
{0 480} SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the	{0 480}		

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{0 480}	Continued From page 1 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 had the potential to affect all residents of the assisted living 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 the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report, dated August 1, 2023, for the specific Minnesota Food Code deficiencies.	{0 480}		
{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	{0 660}		

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{0 660}	Continued From page 2 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 baseline testing and history and symptom screening and TB training for one of three employees (registered nurse (RN)-J). 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: RN-J was hired April 24, 2023, and provided direct cares for the licensee's residents. RN-J lacked an employee record and documentation of completion of TB training, a history and symptom screening form, and documentation of either a blood test or tuberculin skin test (TST) to rule out TB infection.	{0 660}		

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{0 660}	Continued From page 3 On August 1, 2023, at 12:20 p.m., licensed assisted living director (LALD)-A stated he did not have TB screening or training on record for RN-J. -at 12:23 p.m., RN-B stated the licensee would have employees complete the TB blood test going forward. The Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, noted, "The purpose of this manual is to assist health care facilities in Minnesota to understand what is needed to be in compliance with Minnesota laws revised in 2013 regarding TB prevention and control, and to provide tools for implementing legal regulations and best practices in their settings." This included, Baseline TB screening is required for all health care workers (HCW). Baseline TB screening consists of three components: 1. Assessing for current symptoms of active TB disease; 2. Assessing TB history; 3. Testing for the presence of infection with Mycobacterium tuberculosis by administering either a two-step TST or single IGRA; and An employee may begin working with patients after a negative TB symptom screen (i.e., no symptoms of active TB disease) and a negative IGRA or TST (i.e., first step) dated within 90 days before hire. The second TST may be performed after the HCW starts working with patients." The licensee's Infection Control Tuberculosis Screening policy dated July 1, 2021, included "Staff whose essential job functions require work within the same air space of home care clients	{0 660}		

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{0 660}	Continued From page 4 will be screened and tested for tuberculosis prior to the staff being exposed to clients. Baseline (upon hire) screening will be completed, but serial (annual) screening will only be required with increased occupational risk or exposure. Screening will be conducted as follows: 1. New staff will be screened for active signs of TB using the Baseline TB Screening Tool for HCWs ; 2. New staff will have an IGRA blood test with results documented on the Baseline TB Screening Tool for HCWs; 3. No staff will be permitted to begin work where the work involves sharing the air space with residents until the negative results of the first Mantoux are read and documented or a negative IGRA blood test result is received and documented; 4. Staff TB screening results will be kept in each employee medical file; and 5. Staff should be screened for signs and symptoms on an annual basis." No further information was provided.	{0 660}		

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

Type: Follow-Up
Date: *08/01/23*
Time: 11:30:41
Report: 1021231231

Food and Beverage Establishment Inspection Report

Location:
Restful Home LLC
Restful Home Restaurant
1000 Reaney Avenue
St Paul, MN55106
Ramsey County, 62

Establishment Info:
ID #: 0038988
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 6513249591
ID #:

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

The following orders previously issued on 04/03/23 have NOT been corrected.

4-300 Equipment Numbers and Capacities

4-302.14 ***** Priority 2 *****

MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.

NO TEST KIT ON-SITE TO MEASURE THE CONCENTRATION OF BLEACH. PROVIDE. REPEAT 08/01/23.

Issued on: 04/03/23 *Comply By: 04/10/23*

4-500 Equipment Maintenance and Operation

4-501.11AB

MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.

1ST FLOOR DISH MACHINE IS CURRENTLY NOT WORKING. ESTABLISHMENT ALREADY SERVICED DISH MACHINE BUT IT NEEDS A PART THAT HAS BEEN ORDERED. STAFF ARE USING THE 2ND FLOOR DISH MACHINE TO CLEAN AND SANITIZE DISHES AND UTENSILS.

Issued on: 04/03/23 *Comply By: 04/24/23*

No NEW orders were issued during this inspection.

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

TODAY'S FOLLOW UP WAS TO ADDRESS AND CLEAR PREVIOUSLY WRITTEN ORDERS FROM A FULL INSPECTION CONDUCTED ON 04/03/23. 11 OUT OF 13 ORDERS WERE CLEARED FROM THE REPORT.

Type: Follow-Up
Date: *08/01/23*
Time: 11:30:41
Report: 1021231231
Restful Home LLC

Food and Beverage Establishment Inspection Report

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Minnesota Department of Health inspection report number 1021231231 of 08/01/23.

Certified Food Protection Manager: YER XIONG

Certification Number: FM117399 Expires: 06/21/26

Inspection report reviewed with person in charge and emailed.

Signed: _____
LENG XIONG
LALD

Signed: _____
Melissa Ramos
Environmental Health Specialist
Metro District Office
651-201-4495
Melissa.Ramos@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF CONDITIONAL LICENSE

Electronically Delivered

May 10, 2023

Licensee
Restful Home LLC
1000 Reaney Avenue
Saint Paul, MN 55106

RE: Conditional License Number 408395
Health Facility Identification Number (HFID) 33425
Project Number(s) SL33425015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on April 5, 2023, for the purpose of assessing compliance with state licensing statutes. Based on the survey results you were found not to be in substantial compliance with the laws pursuant to Minnesota Statutes, Chapter 144G.

As a result, pursuant to Minn. Stat. § 144G.20, MDH is issuing a 90-day conditional license due to expire on **August 8, 2023**.

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

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

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

MDH may assess fines based on the level and scope of the correction orders outlined below. The total amount of **potential** fines that may be assessed related to these correction orders is $24,500.00. **MDH is not imposing these fines against your license at this time.**

St - 0 - 0495 - 144g.41 Subd. 1 (14) - Minimum Requirements - $3,000.00
St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00
St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required - $3,000.00
St - 0 - 1380 - 144g.61 Subd. 2 (b) - Training And Evaluation Of Unlicensed Personn - $3,000.00
St - 0 - 1610 - 144g.70 Subd. 2 (a-B) - Initial Reviews, Assessments, And Monitoring - $3,000.00
St - 0 - 1630 - 144g.70 Subd. 3 - Temporary Service Plan - $3,000.00
St - 0 - 1690 - 144g.71 Subdivision 1 - Medication Management Services - $3,000.00
St - 0 - 1770 - 144g.71 Subd. 9 - Documentation Of Medication Setup - $3,000.00
St - 0 - 1940 - 144g.72 Subd. 3 - Individualized Treatment Or Therapy Management - $3,000.00

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. **If corrections are not made, MDH may impose fines as described above and in accordance with Minnesota Statutes Chapter 144G.**

The correction order documentation should include the following:

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

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

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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.

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

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

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

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

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

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

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

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

d. Reports: The RN consultant will provide MDH with regular reports at intervals specified by MDH. Reports will begin on a weekly basis until MDH notifies Restful Home LLC and the RN consultant about a change. Each report will be electronically submitted to Jonathan Hill, Surveyor Supervisor, State Evaluation Team, Health Regulation Division, at jonathan.hill@state.mn.us. Jonathan Hill can be reached at 651-201-3993 (office) with questions about reports. The content of the reports will include information such as:

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

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

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

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

RESULTS OF FOLLOW-UP EVALUATION DURING THE CONDITIONAL LICENSE PERIOD:
MDH will determine if Restful Home LLC is in substantial compliance based on the results of the follow up survey. MDH will make this determination within the 90-day conditional license period. If MDH determines Restful Home LLC is in substantial compliance on the follow up survey, MDH will remove the conditions from Restful Home LLC's assisted living facility license, and Restful Home LLC will correct violations identified during the survey to come into substantial compliance. If MDH determines Restful Home LLC is not in substantial compliance, MDH may take additional enforcement action against Restful Home LLC, including placement of additional conditions, issuing a second conditional license, or employ any of the enforcement tools listed in Minn. Stat. § 144G.20 up to and including immediate temporary suspension and revocation.

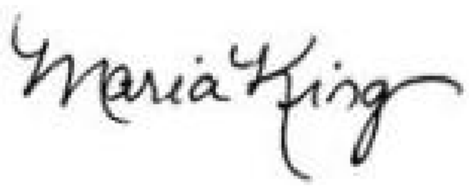
REQUESTING A HEARING:
Pursuant to Minn. Stat. §144G.20, Subd. 17 (c), the licensee may appeal an order immediately temporarily suspending a license or issuing a conditional license. The appeal must be made in writing by certified mail or personal service. If mailed, the appeal must be postmarked and sent to the commissioner within five calendar days after the license holder receives notice. If an appeal is made by personal service, it must be received by the commissioner within five calendar days after the license holder received the order. The request for hearing should be addressed to:

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

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 Jonathan Hill directly at: 651-201-3993.

Sincerely,



Maria King, RN
Division Director

Minnesota Department of Health
Health Regulation Division

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33425	A. BUILDING: _____ B. WING _____	04/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RESTFUL HOME LLC	1000 REANEY AVENUE SAINT PAUL, MN 55106

(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: SL33425015 On April 3, 2023, through April 5, 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 eight active residents, all of whom received services under the Assisted Living Facility license. On April 3, 2023, at approximately 7:30 p.m immediate correction orders were issued for licensing orders 0495, 1290, 1610, and 1940. On April 4, 2023, at approximately 2:45 p.m., immediate correction orders were issued for licensing orders 1380, 1630, 1690, and 1770. As of April 5, 2023, at approximately 1:00 p.m., the immediacy of licensing orders 1290, 1380, 1610, 1630, 1690, 1770, and 1940 were removed, the scopes and levels remained	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facility 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.	

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0 000	Continued From page 1 unchanged. As of April 5, 2023, at approximately 1:50 p.m., at the time of survey exit, immediacy of licensing order 0495 was not removed.	0 000		
0 250 SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4, or interferes with or impedes access by the Office of Ombudsman for Mental	0 250		

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0 250	Continued From page 2 Health and Developmental Disabilities according to section 245.94, subdivision 1; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to show they met the requirements of licensure, by attesting the managerial officials who oversaw the day-to-day operations understood applicable statutes and rules; nor developed and/or implemented current policies and procedures as required 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	0 250		

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0 250	Continued From page 3 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: The licensee had an assisted living license issued on July 1, 2022, with an expiration date of June 30, 2023. During the entrance conference on April 3, 2023, at 11:45 a.m., licensed assisted living director (LALD)-A stated the licensee's employees in charge of the facility were familiar with the assisted living regulations and the licensee provided medication and treatment management services. The licensee's Application for Assisted Living License, section titled Official Verification of Owner or Authorized Agent, (page four and five of the application), identified, I certify I have read and understand the following: [a check mark was placed before each of the following]: - I have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section] 144G.45, 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.	0 250		

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0 250	Continued From page 4 - 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 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	0 250		

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0 250	Continued From page 5 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 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. Application for Assisted Living Provisional License, page 17, was signed by LALD-A on May 25, 2021. 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) conducting and handling background studies on employees;	0 250		

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0 250	Continued From page 6 (3) orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; (4) handling complaints regarding staff or services provided by staff; (5) conducting initial evaluations of residents' needs and the providers' ability to provide those services; (6) 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; (7) orientation to and implementation of the assisted living bill of rights; (8) infection control practices; (9) reminders for medications, treatments, or exercises, if provided; (10) conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards; (11) ensuring that nurses and licensed health professionals have current and valid licenses to practice; (12) medication and treatment management; (13) delegation of tasks by registered nurses or licensed health professionals; (14) supervision of registered nurses and licensed health professionals; and (15) supervision of unlicensed personnel performing delegated tasks. During interviews on April 3, April 4, and April 5, 2023, LALD-A, registered nurse (RN)-B, unlicensed personnel (ULP)-D, and ULP-E indicated the licensee provided the following	0 250		

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0 250	Continued From page 7 services: resident assessments, medication and treatment management, staff orientation and training, and delegation of tasks by RN's to ULP's, but failed to implement the corresponding policies and procedures, as required. An Assisted Living Facility (ALF) on-site survey occurred between April 3, 2023, at 10:00 a.m., through April 5, 2023, at 2:00 p.m. LALD-A was present for the survey on April 3, 2023 at 11:19 a.m., until April 3, 2023, at 2:10 p.m. LALD-A stated he needed to leave to go to his other place of employment and would only be available by phone. LALD-A was absent from the facility on April 4, 2023. On April 5, 2023, at approximately 1:00 p.m., LALD-A arrived at the facility. An informal exit conference was held with LALD-A and RN-B on April 5, 2023, at 1:30 p.m. As a result of this survey, the following orders were issued: 0250, 0340, 0430, 0460, 0480, 0485, 0490, 0495, 0510, 0550, 0630, 0650, 0660, 0680, 0800, 0810, 0900, 0950, 1290, 1370, 1380, 1440, 1460, 1530, 1610, 1620, 1630, 1640, 1690, 1710, 1730, 1760, 1770, 1820, 1880, 1930, 1940, 1950, 1960, 1970, and 2240, 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		
0 430 SS=C	144G.40 Subd. 2 Uniform checklist disclosure of services	0 430		

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0 430	Continued From page 8 (a) All assisted living facilities must provide to prospective residents: (1) a disclosure of the categories of assisted living licenses available and the category of license held by the facility; (2) a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and (3) an oral explanation of the services offered under the contract. (b) The requirements of paragraph (a) must be completed prior to the execution of the assisted living contract. (c) The commissioner must, in consultation with all interested stakeholders, design the uniform checklist disclosure form for use as provided under paragraph (a). This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a copy of the uniform checklist disclosure of services (UDALSA) with the required content for two of two residents (R1, R3). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include:	0 430		

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0 430	Continued From page 9 R1 was admitted on March 9, 2023, and received services including assistance with housekeeping, and medication administration. R3 was admitted on June 9, 2022, and received services including assistance with activities of daily living (ADLs), toileting, housekeeping, meals, laundry, and medication administration. R1 and R3's records lacked documentation they received a UDALSA, to include: -a disclosure of the categories of assisted living licenses available and the category of license held by the facility; -a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license the facility did not provide; and -an oral explanation of the services offered under the contract. On April 3, 2023, at 12:17 p.m., during the entrance conference, licensed assisted living director (LALD)-A was not familiar with the UDALSA document. LALD-A stated the residents sign an agreement on rent, but they had not provided an assisted living contract, and did not have any signed documentation on file for any residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 430		
0 460 SS=E	144G.41 Subdivision 1 Minimum requirements	0 460		

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0 460	Continued From page 10 (5) provide a means for residents to request assistance for health and safety needs 24 hours per day, seven days per week; (6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract; (7) permit residents access to food at any time; (8) allow residents to choose the resident's visitors and times of visits; (9) allow the resident the right to choose a roommate if sharing a unit; (10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living facility must not lock a resident in the resident's unit; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide a means for residents to request assistance for health and safety needs 24 hours a day, seven days a week for two of eight residents (R2, 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) 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:	0 460		

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0 460	Continued From page 11 R3 R3 was admitted June 9, 2022, and had diagnoses including major depressive disorder, post-traumatic stress disorder and substance abuse. R3's registered nurse (RN) assessment, dated January 20, 2023, indicated R3 needed assistance with activities of daily living (ADLs), was incontinent, needed occasional supervision or standby help to walk, and had two falls in the previous three months. On April 3, 2023, at 10:37 a.m., unlicensed personnel (ULP)-D stated she "checked in" on residents "every hour or two", but that residents could use a phone to call for help. ULP-D further stated R3, who lived on the second floor, did not have a phone. ULP-D added there were cameras in the facility and she could monitor R3 from the monitor on the first floor. ULP-D demonstrated the camera view for surveyors and stated it only showed the hallway, and she could not see inside R3's room. On April 3, 2023, at 11:54 a.m., during the entrance conference, licensed assisted living director (LALD)-A stated all residents except R3 had a cell phone they could use to call staff if they needed assistance. LALD-A stated R3 had a third-party emergency call pendant, and since his room was directly above the caregivers' office, they would hear if he fell. LALD-A further stated R3 previously owned a cell phone at times, but "kept losing them". On April 4, 2023, at 11:45 a.m., R3's room was observed to be located on the 2nd floor of the facility, mid-hallway on the right hand side. R3	0 460		

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0 460	Continued From page 12 stated that he did not have a phone. R3 indicated that his phone was stolen awhile ago when he was outside of the facility. He said that if he needed help he would make some noise and yell out to get the attention of a caregiver. R2 On April 3, 2023, at 10:50 a.m., LALD-A stated R2 "just moved in on Friday (admitted)" March 31, 2023. R2 lacked a medical record, including an initial RN assessment, completed at the time of admission or prior to receiving services. On April 4, 2023, at 11:45 a.m., R2's room was observed to be located on the 2nd floor of the facility, at the end of the hallway. R2 stated he did not have a call button, but if he needed help, he would, "just go ask them". R2 stated he had the phone number for LALD-A, but did not know the phone number to reach the caregivers. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 460		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by:	0 480		

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0 480	Continued From page 13 Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This had the potential to affect all eight residents of the assisted living 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 the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report, dated April 3, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 485 SS=C	144G.41 Subd 1. (13) (i) (A) and (C) Minimum Requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (A) menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in	0 485		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33425	A. BUILDING: _____ B. WING _____	04/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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0 485	Continued From page 14 menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes; and (C) the facility cannot require a resident to include and pay for meals in their contract; (ii) weekly housekeeping; (iii) weekly laundry service; This MN Requirement is not met as evidenced by: Based on observation, and interview, the licensee failed to ensure at least three nutritious meals were served daily, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) "My Plate" guidelines, including seasonal fresh fruit and fresh vegetables. The licensee further failed to provide a menu to all residents and notify residents in advance of menu changes. This had the potential to affect all eight residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee failed to ensure the following: - meals with seasonal fresh fruit and vegetables; - meals according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines; - menus must be prepared at least one week in advance and made available to all residents;	0 485		

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0 485	Continued From page 15 - residents be informed in advance of menu changes; and - meal substitutions of similar nutritional value if a resident refused a food that was served. On April 3, 2023, at 10:35 a.m., unlicensed personnel (ULP)-D stated there was a menu posted on the wall, but usually she just made what the residents wanted for meals. The licensee's posted menu, undated, included breakfast, lunch, and dinner meals, labeled Monday through Sunday. The menu indicated, "This is a "tentative" daily menu to help the staff with ideas or options to serve yet it may change due to the current good / produce available." The menu indicated lunch for Mondays was, "Eggs & noodles (premade noodles) *May serve w/fruit & veggies". On April 3, 2023 (Monday), at 1:56 p.m., R2 was observed sitting at the table alone eating a lunch meal that consisted of 2 hot dogs with potato chips. ULP-D stated she prepared the lunch for R2. When asked if they served vegetables, ULP-D stated "sometimes". R2 stated, "ketchup is my vegetable". ULP-D then opened the refrigerator and asked R2 if he would like any fruit, which R2 declined. ULP-D further stated she was not familiar with the USDA My Plate guide. The licensee's posted menu indicated the following meals for Tuesdays: Breakfast: "Toast, breakfast sausages, bacon, eggs, pancakes, waffle & juice, coffee or tea * May serve w/fruit & veggies"; Lunch: "Spaghetti * May serve w/fruit & veggies"; and Dinner: "Hamburger, fries, or chips".	0 485		

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0 485	Continued From page 16 On April 4, 2023 (Tuesday), at 8:30 a.m., ULP-G was observed delivering breakfast plates to residents. ULP-G stated the breakfast consisted of hash browns, scrambled eggs and chicken nuggets. ULP-G stated the USDA My Plate Guide looked familiar, but was not trained on it by the licensee. On April 4, 2023, at 8:42 a.m., the main floor refrigerator was observed to contain 3 individual-sized plastic storage cups containing grapes. ULP-E stated staff would divide fresh fruit into individual cups that were available to the residents at any time. ULP-E stated the licensee needed to purchase more fruit. When asked if they served vegetables, ULP-E stated they would cook frozen vegetables, such as broccoli and cauliflower, which the residents enjoyed with cheese. The licensee's posted menu indicated lunch for Wednesday was "Eggs and Sausages * May serve w/fruit & veggies". On April 5, 2023 (Wednesday), at 10:45 a.m., R5 asked ULP-G, "Do I have any pizza left?" ULP-G offered to make the pizza for R5. R5 stated she was not aware of a menu. When surveyors indicated the menu posted on the wall, R5 stated she was blind and could not see the menu on the wall. When asked what was served for lunch and dinner the previous day, R5 stated she did not know, and did not remember spaghetti being served for lunch, or hamburgers being served for dinner, as was indicated on the menu. R5 further stated they did not "usually" serve vegetables, and added, "I like salads, but they are hard to get here." On April 5, 2023, at 11:19 a.m., R7 stated she	0 485		

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0 485	Continued From page 17 was not aware of any menu, and "I just come out when food is ready." R7 stated fruit was available in the plastic storage cups, but she did not like how the fruit was mixed together. When asked if vegetables were available, R7 paused, then stated, "I guess?". On April 5, 2023, at 1:19 p.m., licensed assisted living director (LALD)-A stated the menu posted was a weekly rotating menu, but they had not been following the menu exactly. LALD-A further stated breakfast was casual and residents could eat when they wanted and chose from what foods were available, but stated lunch and dinner should be prepared for the residents at scheduled times. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		
0 490 SS=F	144G.41 Subd 1 (13) (ii)-(vii) Minimum requirements (iv) upon the request of the resident, provide direct or reasonable assistance with arranging for transportation to medical and social services appointments, shopping, and other recreation, and provide the name of or other identifying information about the persons responsible for providing this assistance; (v) upon the request of the resident, provide reasonable assistance with accessing community resources and social services available in the community, and provide the name of or other identifying information about persons responsible for providing this assistance; (vi) provide culturally sensitive programs; and	0 490		

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0 490	Continued From page 18 (vii) have a daily program of social and recreational activities that are based upon individual and group interests, physical, mental, and psychosocial needs, and that creates opportunities for active participation in the community at large; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide a daily program of social and recreational activities that are based upon individual and group interests, physical, mental, and psychosocial needs, and that creates opportunities for active participation in the community at large This had the potential to affect all eight residents 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: On April 3, 2023, at 11:45 a.m., during entrance conference licensed assisted living director (LALD)-A stated they were working on providing an every Friday activity outing to local parks, but he stated those had not started yet. LALD-A indicated they were working on the transportation to put that in place. LALD-A further stated there was no current daily program of activities at the facility. On April 5, 2023, at 11:26 a.m., R7 stated there	0 490		

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0 490	Continued From page 19 were no activities, and never any outings, but stated she, "heard they might be planning some things like that," and, "once in a blue moon we play bingo". -at 11:27 a.m., R5 stated they used to play bingo, but added, "that has not happened for a while". On April 3 through April 5, 2023, during on-site survey hours, the surveyors did not observe activities offered to any residents of the facility. The licensee's Activity Program policy, revised July 1, 2010, indicated, "A variety of recreational, religious, educational, cultural and social programs will be available for resident's participation. Both the Activity Coordinator and the Personal Care Attendants will be responsible for conducting these activities." The policy further indicated, "Residents can find a brief description of scheduled activities in the monthly newsletter and activity calendar." No further information was provided. TIME PERIOD TO CORRECT: Twenty-one (21) Days	0 490		
0 495 SS=I	144G.41 Subd. 1 (14) Minimum Requirements (14) provide staff access to an on-call registered nurse 24 hours per day, seven days per week This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure staff had access to the registered nurse (RN), 24 hours per day, seven days per week. RN-B the licensee employed also	0 495		

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0 495	Continued From page 20 worked full-time on the night shift at a local hospital. This affected all residents and unlicensed staff. This resulted in an immediate correction order issued on April 3, 2023, at approximately 7:30 p.m. 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). Findings include: RN-B was hired July 28, 2022. On April 3, 2023, at 10:50 a.m. licensed assisted living director (LALD)-A stated R2 "just moved in on Friday (admitted)" March 31, 2023. R2 lacked an electronic medical record (EMR), including an initial RN assessment completed at the time of admission or prior to the initiation of services. On April 3, 2023, at 11:45 a.m., LALD-A stated RN-B worked Monday through Wednesday on day shift and available Thursday and Friday, if needed as well as available 24/7 on call. LALD-A indicated that RN-B also had another job at the hospital on night shift. LALD-A stated he was not sure if RN-B was able to leave her other job during the night if the RN was needed at the facility.	0 495		

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0 495	Continued From page 21 On April 3, 2023, at 1:46 p.m., unlicensed personal (ULP)-D stated, R2 was transported by R2's case worker, for admission to the licensee on March 31, 2023, at approximately 3:00 p.m. ULP-D stated, she called RN-B to provide an update that R2 arrived at the facility. ULP-D indicated that RN-B instructed ULP-D to administer the medications over the weekend, that were set up for R2, provided by case worker. ULP-D stated, she was unable to document the medications on the weekend that were administered, due the to R2 not being set up in the electronic medical record. ULP-D also stated, that RN-B indicated that she had to work the weekend R2 admitted and she would be back at the facility on Monday or Tuesday April 3, 2023, or April 4, 2023, to set up R2 in the electronic medical record. On April 3, 2023, at 3:58 p.m., RN-B stated she worked full time night shift at a hospital. RN-B further stated the hospital would not let her leave her hospital shift to go to attend a resident at the assisted living facility. RN-B stated if she was not able to get the the facility, she would direct the caregivers over the phone and or instruct the caregivers to call 911 for emergency assistance. In addition, RN-B acknowledged that she talked on the phone to ULP-D when R2 arrived to the facility on March 31, 2023. On April 3, 2023, at 7:35 p.m., the Minnesota Department of Health (MDH) issued four immediate correction orders including licensing order 0495, to the licensee via email. The email included a request for a reply to confirm receipt as well as to submit an immediate plan of correction.	0 495		

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0 495	Continued From page 22 On April 4, 2023, at 12:14 a.m., the licensed assisted living director (LALD)-A, emailed the survey supervisor, in reply to the previous message. LALD-A stated, via email, that "we would work on these corrections immediately and promptly. We will update as soon as possible once this is done." The licensee failed to provide an immediate plan of correction. On April 4, 2023, at 8:41 a.m., the survey supervisor replied, via email, to LALD-A, "Please read the letter carefully, you need to provide me a plan of correction documentation on how you will correct. The required aspects of the plan and how to write it, are highlighted for you below. If you don't understand or are unclear, please reach out to me. You will need to write this to address each of the four immediate orders sent to you yesterday for these tags: 0495, 1290, 1610, 1940." The email further directed that the supervisor, "will be looking for you to provide the following, in the plan of correction documentation today," and detailed the required elements of the plan of correction. The email closed indicating, "Once the above criteria is submitted and approved by the survey supervisor, the immediacy of the order will be lifted." On April 4, 2023, at 3:27 p.m., LALD-A emailed the survey supervisor indicating they were working on the correction plans and LALD-A would take the offer of a phone conversation with the survey supervisor. On April 4, 2023, at 5:00 p.m., the survey supervisor responded to LALD-A, via email, after an informal conference by phone with LALD-A and RN-B was completed. The survey supervisor noted in email, "as we discussed, include what you have done, changed and trained on;	0 495		

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0 495	Continued From page 23 document and be prepared for evaluators or I to request to review this documented evidence to remove immediacy." The email further indicated the supervisor discussed with LALD-A, the requirements for an RN per 144G, and, "the present RN schedule is not sufficient to meet minimum requirements." On April 4, 2023, at 6:25 p.m., LALD-A replied to survey supervisor, via email, with attached correction plans for immediate correction order identification numbers 1290, 1610, and 1940. LALD-A also indicated he planned to have a consultation with a registered nurse at 9:00 p.m., on April 4, 2023, to address correction order identification number 0495. LALD-A stated, "I am hoping to address the correction plan for this item to you tonight. My RN will be at the facility tomorrow and be available until 6:30 PM." On April 4, 2023, at 11:26 p.m., LALD-A sent an email communication to the survey supervisor, with correction plans on immediate correction order identification numbers 1380, 1630, 1690, and 1770. LALD-A further wrote, "Please note that I am very closed [sic] to having an agreement with a back up RN. I will update you no later than 4 PM on Wednesday 4/5/2023." On April 5, 2023, at 1:30 p.m., during the exit conference, LALD-A stated he had spoken to the owner of a sister facility regarding an additional RN, but had not yet heard back from them. On April 5, 2023, at 1:54 p.m., the surveyors sent an email to LALD-A announcing the completion of the survey. At the time of survey exit, the immediacy of correction order tag identification 0495 was not lifted.	0 495		

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0 495	Continued From page 24 On April 5, 2023, at 2:36 p.m., the survey supervisor stated, via email, to LALD-A, regarding tag identification number 0495, "the immediacy of this order is not removed at the time of exit [April 5, 2023], at approximately 1:50 PM; the scope and level remain the same (level 3, widespread)". The survey supervisor further indicated the immediacy was lifted, April 5, 2023, at 1:00 p.m., for correction orders 1290, 1380, 1610, 1630, 1690, 1770, and 1940. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE	0 495		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish an infection control program to comply with accepted health care, medical, and nursing standards for infection control, as directed by the Centers for Disease Control and Prevention (CDC), including:	0 510		

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0 510	Continued From page 25 registered nurse (RN) oversight, monitoring and training to prevent the potential spread of infections, the licensee failed to ensure direct care staff appropriately gloved and performed adequate hand hygiene (HH) for 1 of 2 unlicensed personnel (ULP)-E; the licensee failed to ensure two of two staff (ULP-E, ULP-D) received required basic infection control training and also lacked training for blood borne pathogens. This had the potential to affect all eight (8) residents who lived at the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: During the entrance conference on April 3, 2023 at 10:00 a.m. licensed assisted living director (LALD)-A stated the facility could provide services including assistance with activities of daily living (ADL), medication management, chronic illness management and wound care. LALD-A stated the treatments the facility could provide included blood glucose monitoring, application of compression stockings and use of CPAP (continuous positive airway pressure)/BIPAP (bilevel positive airway pressure). LALD-A stated the RN was available in person only three days per week 11:00 a.m. to 3:00 p.m. on Monday, Tuesday, Wednesday; was available "as needed" on Thursday and Friday; and was "on call" for the facility twenty-four hours per day. LALD-A stated	0 510		

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0 510	Continued From page 26 the RN worked full time at another job at a hospital on the night shift. LALD-A stated the facility did not have a back up RN, or RN available 24 hours per day, seven days per week. ULP-E and ULP-D were hired on April 25, 2022, and November 15, 2022, respectively, to provide direct care services for residents. Both ULPs lacked an employee record, and documentation of training, including but not limited to: basic infection control, hand washing, and blood-borne pathogens. On April 3, 2023, at 1:31 p.m., LALD-A stated the facility had not developed a staff training procedure. LALD-A stated he trained staff on professional etiquette and interactions with residents, but there had not been any specific caregiver training from a RN. LALD-A further stated training was not documented. On April 3, 2023, at 3:58 p.m. RN-B stated she worked another full time night shift job at a hospital, could not leave the hospital while on her shift and slept during the afternoons before returning to the hospital. RN-B stated she receive calls or could "call the facility" and direct the staff to call 911 if needed. R1 had diagnoses to include diabetes. Although R1's record lacked treatment orders, the record included a Department of Human Services (DHS) "Customized Living Worksheet" (DHS form 6790G) dated February 21, 2023. The form indicated R1 needed "health related assistance " with delegated tasks including blood glucose (BG) checks daily. On April 3, 2023, at 1:59 p.m., unlicensed personnel ULP-D, was observed to gather	0 510		

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0 510	Continued From page 27 supplies to check R1's BG level. R1 was out of the facility and unavailable. ULP-D stated the BG check would be completed by the evening shift staff and she would document she did not complete because he was not available. R6 had diagnoses to include diabetes, the Master Care plan dated March 3, 2023, identified R6 needed assistance with application and removal of CPAP (continuous positive air pressure), the facility set up and managed medications including insulin (Flexpen injection) and needed "reminders" with checking BG. On April 3, 2023, from 4:08 p.m. to 4:26 p.m., ULP-E was continuously observed during medication administration. ULP-E walked upstairs to the second floor, retrieved keys to the medication cabinet, unlocked the door, and retrieved R1's medication set-up box from the cabinet. Without performing HH, ULP-E donned gloves, and transferred the set-up medications from a bag into a medication cup, returned the box and closed the cabinet. ULP-E knocked and entered R1's room, and administered the medications with water. ULP-E then returned to the medication cabinet, and doffed gloves. Without performing HH, ULP-E donned a clean pair of gloves, then retrieved R6's medication and transferred one pill into a medication cup. ULP-E stated she would also need to get R6's blood glucose level and blood pressure, but that R6 had been "sick with the flu," so might refuse. ULP-E knocked on R6's door to gain entry to administer medications. R6 declined to open the door at that time. ULP-E stated she would re-approach R6, and doffed gloves. No HH was observed. On April 3, 2023, at 4:26 p.m., ULP-E stated she had HH training from the previous RN (not RN-B).	0 510		

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0 510	Continued From page 28 ULP-E stated HH was performed when first entering the facility at the start of the shift, and always performed HH at the end of the shift, before going home. ULP-E stated they did not perform HH at other times, but always changed gloves between residents when giving medications. On April 4, 2023, at 10:07 a.m., RN-B stated she was hired for "medication set up and assessments August of 2022." RN-B further stated she was not in charge of the infection control program and had not overseen any training or infection control monitoring. RN-B verified the facility lacked a required infection control program. On April 5, 2023, at 10:11 a.m., RN-B stated, R1 was not independent with BG monitoring, R1's glucometer was locked in the medication cabinet, and staff brought the glucometer to R1 when it was time to test BG. RN-A stated, there was not a signed order for R1's BG monitoring. When policies were requested, the following Peaceful Living (previous company) policies and procedures all dated as revised July 1, 2010 (dated prior to 144G), were provided, including the following: - The Use of Gloves policy directed gloves were to be worn when there may be direct contact between an employee and contaminated objects. The policy listed gloves should be worn including when potential contamination with blood or body fluids. The procedure further direct to wash hands before applying gloves and "rewash" hands when gloves were removed. - The Hand Washing policy indicated hand washing must occur after removal of gloves or other protective equipment, and before and after	0 510		

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0 510	Continued From page 29 medication administration. The licensee lacked current policies and procedures for an infection control program. The CDC guidance titled, Hand Hygiene in Healthcare Settings dated January 8, 2021, indicated healthcare personnel (HCP) should perform HH before and after all patient (resident) contact, contact with potentially infectious material, and immediately before donning and after doffing gloves. The CDC indicated gloves should be changed and HH performed before moving from work on a soiled body site to a clean body site on the same patient. The CDC recommended alcohol-based hand sanitizer (ABHS) with 60% to 95% alcohol, or washing hands with soap and water for at least 15 seconds. The CDC's Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings webpage document dated, November 29, 2022, identified, "Adherence to infection prevention and control practices is essential to providing safe and high quality patient care across all settings where healthcare is delivered. This document concisely describes a core set of infection prevention and control practices that are required in all healthcare settings, regardless of the type of healthcare provided." The document identified practices were selected from among existing CDC recommendations and represented fundamental standards of care that were not expected to change based on emerging evidence or to be regularly altered by changes in technology or practices, and were applicable across the continuum of healthcare settings, indicating, "The practices outlined in this document are intended to serve as a standard reference and reduce the need to repeatedly	0 510		

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0 510	Continued From page 30 evaluate practices that are considered basic and accepted as standards of medical care." The scope section of the document further identified development of core practices for an infection control program also applied to "assisted living communities." In addition, the document referenced core practices that should be implemented in all settings included, but not limited to: 1. Leadership support - including the governing body of the healthcare facility or organization was accountable for the success of infection prevention activities and to assign one or more qualified individuals with training in infection prevention and control to manage the facility's infection prevention (control) program. 2. Education and Training of Healthcare Personnel on Infection Prevention - including providing job-specific, infection prevention education and training to all healthcare personnel for all tasks; before individuals were allowed to perform their duties and at least annually as a refresher; the document directed to provide additional training for recognized lapses in adherence and to address newly recognized infection transmission threats; provide written infection prevention policies and procedures that were available, current, and based on evidence-based guidelines 3. Patient, Family and Caregiver Education - including provide appropriate infection prevention education to patients, family members, and visitors. 4. Performance and Monitoring Feedback - including identifying and monitoring adherence to infection prevention practices and infection control requirements; monitor the incidence of infections that may be related to care provided at the facility and act on the data and use information collected through surveillance to	0 510		

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0 510	Continued From page 31 detect transmission of infectious agents in the facility. 5. Standard Precautions - including use Standard Precautions to care for all residents. Standard Precautions included: hand hygiene, environmental cleaning and disinfection, injection and medication safety, risk assessment with use of appropriate personal protective equipment (e.g., gloves, gowns, face masks) based on activities being performed, and minimizing potential exposures. Cleaning of medical equipment, such as blood glucose meters or CPAP, according to the manufacturer's guidelines. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of	0 550		

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0 550	Continued From page 32 Health. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post the required information related to the grievance procedure and contact information for the Office of Ombudsman for Long-Term Care (OOLTC) and Mental Health and Developmental Disabilities. This had the potential to affect all eight residents receiving assisted living services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On April 3, 2023, at 10:30 a.m., the surveyor observed the common areas of the facility. The facility lacked a posting of the grievance procedure and OOLTC contact information. On April 3, 2023, at 11:20 a.m., licensed assisted living director (LALD)-A acknowledged the grievance procedure with staff contact information was not posted. LALD-A further acknowledged, the OOLTC information and contact number was also not posted. The licensee's Complaint Policy and Procedure, dated July 1, 2010, indicated, "Every Assisted Living resident will be informed as to how to file a complaint with the Offices of Health Facility Complaints and the Ombudsman for Older	0 550		

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0 550	Continued From page 33 Adults, in conjunction with the Home Care Bill of Rights. Every resident will also be informed as to additional options for filing complaints according to the Housing-with-Services contract and the Resident Handbook." and " 2. Home Care Bill of Rights includes specific information on how and where to file a complaint with the Minnesota Department of Health and the Office of Ombudsman, including addresses, mailing addresses, telephone numbers, and fax numbers." The licensee's Grievance Policy, dated July 1, 2010, indicated, "To resolve grievances in a timely and appropriate manner for employees or residents that have concerns or complaints." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
0 630 SS=E	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	0 630		

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0 630	Continued From page 34 by: Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) contained statements of the specific measures to be taken by staff to minimize the risk of abuse for two of two residents (R1, 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) 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 had diagnoses including lumbago (low back pain), major depression and diabetes. R1's record lacked an IAPP including: -an individualized review or assessment of R1's susceptibility to abuse by another individual, including other vulnerable adults; -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. R3 R3 had diagnoses including polysubstance abuse, cognitive deficit, and schizoaffective disorder (a mental disorder characterized by abnormal thought processes and an unstable mood).	0 630		

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0 630	Continued From page 35 R3's registered nurse (RN) assessment, dated January 20, 2023, indicated R3 needed assistance with activities of daily living (ADLs), was incontinent, needed occasional supervision or standby help to walk, and had two falls in the previous three months. The assessment further identified R3 could be physically abusive to property and verbally abusive to staff, and was "disoriented occasionally". The assessment indicated, under "vulnerability," R3, "Is not at risk to be abused". R3's record lacked an IAPP including: -specific interventions for staff to respond to the identified abusive behaviors; -an individualized review or assessment of R3's susceptibility to abuse by another individual, including other vulnerable adults; -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. On April 4, 2023, at 3:00 p.m., RN-B stated both R1 and R3 lacked an IAPP that was individualized with specific details to minimize risk to resident or others. Further, RN-B acknowledged that R1 did not have an IAPP completed upon admission, and she had developed an IAPP after surveyors arrived on site, April 3, 2023. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 650 SS=C	144G.42 Subd. 8 Employee records	0 650		

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0 650	Continued From page 36 (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain employee records with all required content for three of three personnel, registered nurse (RN)-B, and unlicensed personnel (ULP)-D, ULP-E. 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 the potential to affect a large portion or all	0 650		

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0 650	Continued From page 37 the residents). The findings include: RN-B, ULP-D and ULP-E were hired July 28, 2022, November 15, 2022, and April 25, 2022, respectively, and provided direct services for the licensee's residents. RN-B lacked an employee record and the following: - evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; and - current job description, including qualifications, responsibilities, and identification of staff persons providing supervision. ULP-D and ULP-E lacked an employee record and the following: - current job description, including qualifications, responsibilities, and identification of staff persons providing supervision. On April 3, 2023, at 11:47 a.m., during the entrance conference, licensed assisted living director (LALD)-A stated the employee files were not yet completed. LALD-A further stated he did have documentation of a "pay agreement" with RN-B. No employee files or pay agreement was provided. On April 4, 2023, at 10:07 a.m., RN-B stated that upon hire she was not provided a position description. On April 4, 2023, at 3:29 p.m., ULP-E stated she did not remember getting a job description.	0 650		

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0 650	Continued From page 38 The licensee's Personnel Records policy, revised July 1, 2010, indicated a personnel file would be maintained for each employee. The policy further indicated the personnel file for each employee would include, "evidence of current professional licensure, registration or certificate, if required"; and a current job description, which included, "qualifications, responsibilities, and identification of supervisors, if any". No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 650		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a	0 660		

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0 660	Continued From page 39 tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included completion of a TB facility risk assessment, baseline testing and history and symptom screening and TB training for three of three employees, registered nurse (RN)-B, and unlicensed personnel (ULP)-D, ULP-E. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee lacked a facility TB risk assessment that indicated the transmission risk rate for the facility. RN-B, ULP-D, and ULP-E were hired July 28, 2022, November 15, 2022, and April 25, 2022, respectively, and provided direct cares for the licensee's residents. RN-B, ULP-D, and ULP-E all lacked an employee record and documentation of completion of TB training, a history and symptom screening form, and documentation of either a blood test or tuberculin skin test (TST) to rule out TB infection. On April 3, 2023, at 10:30 a.m., ULP-D stated she did not get a new TB test and did not remember filling out a TB screening form when hired. On April 4, 2023, at 10:07 a.m., RN-B stated that	0 660		

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0 660	Continued From page 40 upon hire the licensee did not require documentation of a TB test or completion of a TB history and screening form. RN-B added she previously completed the TB testing required by her other employer. On April 4, 2023, at 3:29 p.m., ULP-E stated she did not complete a TB test or screening for the licensee, but had completed testing previously for another employer. ULP-E stated LALD-A did not ask for a copy of any TB test results. On April 4, 2023, at 10:07 a.m., RN-B stated when they were hired, their responsibilities did not include being in charge of the TB infection control program. RN-B stated a TB risk assessment was not completed for the facility. During the entrance conference on April 3, 2023, at 11:45 a.m., LALD-A stated he was not aware a TB history and symptom screen along with testing were required for all staff upon hire. LALD-A further stated no recently hired staff had been screened for TB or been provided TB training. The Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July 2013 noted training was required at the time of hire and included: pathogenesis, signs symptoms, and the licensee's infection control plan. In addition, baseline screening for all health care workers (HCW) included a history and symptom screen, and testing for the presence of TB infection. The regulations noted a blood test should include the date of the test. According to the regulations, if a HCW had documentation for latent TB, that documentation could be substituted for documentation of a previous positive TST or blood test.	0 660		

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	33425	A. BUILDING: _____ B. WING _____	04/05/2023

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0 660	Continued From page 41 The licensee's Immunizations and Screenings policy dated July 1, 2010, included "Tuberculin screening for employees will occur prior to employment and either every year for Mantoux injections or for two consecutive years for chest x-rays or a physicians note accompanied by documentation of two consecutive negative chest x-rays." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also	0 680		

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0 680	Continued From page 42 working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop a written emergency preparedness (EP) plan with all the required content. This had the potential to affect all residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On April 3, 2023, at 10:30 a.m., upon surveyor entrance to the facility it was observed the licensee lacked posting of emergency exit diagrams. The facility further lacked an emergency disaster plan posted prominently. On April 5, 2023, at 10:07 a.m., registered nurse (RN)-B stated she had not received EP training for the facility. On April 5, 2023, at 10:15 a.m., the licensee's EP plan was reviewed and noted to lack customization to the facility and resident-specific individualization. The licensee's, undated, EP binder, lacked a documented annual review date and individualized emergency procedures to	0 680		

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0 680	Continued From page 43 include the following: -written emergency disaster plan that contained a plan for evacuation, addressed elements of sheltering in place, identified temporary relocation sites, and detailed staff assignments in the event of a disaster or an emergency; -provided building emergency exit diagrams to all residents; -written policy and procedure regarding missing residents; and -provided emergency and disaster training to all staff during the initial staff orientation and annually thereafter and make emergency and disaster training annually available to residents. On April 5, 2023, at 11:45 a.m., R2 stated he had not seen an exit map posted. R2 further stated he had not been told about an emergency plan or escape routes in case of an evacuation. On April 5, 2023, at 1:16 p.m., licensed assisted living director (LALD)-A, stated the EP plan had not yet been reviewed as of the date he took ownership, July 2022. LALD-A further stated there was no additional EP information beyond the binder that was provided for review, and stated licensee had not developed a hazard vulnerability assessment and verified staff had not been trained on EP. The Licensee's Emergency Preparedness Supplies and Review policy dated December 12, 2012, included "[Licensee] recognizes that emergencies occur in daily life and that such emergencies can cause harm or endangerment. The purpose of this policy and procedure, however, is to ensure that unexpected emergencies are handled in a timely and appropriate manner. [Licensee], within reason, will be adequately prepared and supplied to meet	0 680		

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0 680	Continued From page 44 a wide range or emergency or disaster situations in order to protect the health and safety or residents, staff, and visitors." and "2. [Licensee] will ensure a systematic review of emergency preparedness at least quarterly. The following is to be checked or performed every 3 months and documented." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation regarding the health, safety, comfort, and well-being of the residents. This deficient condition had the potential 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	0 800		

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0 800	Continued From page 45 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 April 5, 2023, at 10:00 a.m., a tour of the facility was conducted with unlicensed personnel (ULP)-G, and the following observations were noted: Emergency lighting for the 2nd floor, and for the rear EXIT were not operational. These were required for the lighting of the EXIT pathways in the event of an emergency/power outage. These deficient conditions were visually verified by ULP-G during the tour. Water stains on the main floor ceiling indicated leakage/overflow issues with the upper-level bathroom (men's bathroom). This deficient condition was visually verified by ULP-G during the tour. Caulking in the upper-level bathroom (men's bathroom) had deteriorated around the sink basin, toilet, and shower. Caulking would be provided to protect adjacent areas from seeping water damage and should have been replaced as it became worn and damaged. This deficient condition was visually verified by ULP-G during the tour. The cover plate for the electrical switch in the basement bathroom was missing and needed to be replaced. This deficient condition was visually verified by ULP-G during tour.	0 800		

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0 800	Continued From page 46 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation	0 810		

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0 810	Continued From page 47 drill. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to have fire safety and evacuation plans with the required elements, failed to conduct required drills, and did not complete required training for residents and employees. These deficient practices had the potential 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, 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 of or all the residents). Findings include: A record review and interview were conducted on April 5, 2023, at 11:00 a.m., with unlicensed personnel (ULP)-G on the fire safety and evacuation plan, fire safety and evacuation training for the facility, fire safety, and evacuation drills for the facility. Review of the available documentation indicated the licensee failed to maintain a Fire Safety and Evacuation Plan. The licensee-provided fire safety and evacuation plan was not specific for this facility. This deficient condition was verified by ULP-G. Review of the available documentation for the fire	0 810		

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0 810	Continued From page 48 safety and evacuation plan indicated the licensee failed to describe the employees' actions to be taken in the event of a fire or similar emergency. The provided document did not reflect the actions necessary for the employees of this facility. This deficient condition was verified by ULP-G. Review of the available documentation indicated the licensee failed to provide fire safety and evacuation plans that showed 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. The provided documents contained information that were not relevant to this location or its occupants. The deficient conditions were verified by ULP-G. Review of the available documentation for fire safety and evacuation training indicated that employees failed to receive training on the fire safety and evacuation plans upon hire and at least twice per year thereafter. No documents were available showing that the training was completed. This deficient condition was verified by ULP-G. Review of the available documentation indicated the licensee failed to provide fire safety and evacuation plans that were always readily available within the facility. No documents were provided that were specific to this location for fire and evacuation plans. This deficiency was verified by ULP-G. Review of the available documentation for fire safety and evacuation training indicated that residents capable of assisting in their own evacuation did not receive training on the proper actions at least once per year. This deficiency	0 810		

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0 810	Continued From page 49 was verified by ULP-G. Review of the available documentation for fire safety and evacuation drills indicated that evacuation drills were not performed twice per year, per shift, with at least one drill conducted every other month. No documents were provided to show that this was completed. This deficiency was verified by ULP-G. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 900 SS=F	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37.	0 900		

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0 900	Continued From page 50 (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and execute a written assisted living contract with the required content for two of two residents (R1, 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee lacked documentation they provided to the Office of Ombudsman for Long-Term Care a complete unsigned copy of their assisted living contract. R1 was admitted on March 9, 2023, and received services including assistance with housekeeping, and medication administration. R3 was admitted on June 9, 2022, and received services including assistance with activities of daily living (ADLs), toileting, housekeeping,	0 900		

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0 900	Continued From page 51 meals, laundry, and medication administration. R1 and R3's record lacked documentation that, prior to providing housing or services, R1 and R3 or their representative signed an assisted living contract containing all the terms concerning the provision of: -housing; -assisted living services, whether provided directly by the facility or by management agreement or other agreement; and -the resident's service plan. On April 3, 2023, at 12:17 p.m., during the entrance conference, licensed assisted living director (LALD)-A stated there was a rent agreement, but he did not have an assisted living contract. On April 5, 2023, at 1:19 p.m., LALD-A stated he had no documents signed by any of the residents upon admission. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 900		
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.	0 950		

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0 950	Continued From page 52 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 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 offer the opportunity to identify a designated representative, on a separate form including statutory language, for two of two residents (R1, R3). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include:	0 950		

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0 950	Continued From page 53 R1 was admitted on March 9, 2023, and received services including assistance with housekeeping, and medication administration. R3 was admitted on June 9, 2022, and received services including assistance with activities of daily living (ADLs), toileting, housekeeping, meals, laundry, and medication administration. R1 and R3 lacked an assisted living contract and lacked documentation that indicated R1 and R3 were given the opportunity to designate a representative for certain purposes, on a separate form with required statutory language. On April 3, 2023, at 11:45 a.m., licensed assisted living director (LALD)-A stated, he was not aware of an assisted living contract. He indicated that he may have some agreement at his home office but it was not an assisted living contract or service plan agreement. LALD-A stated, he used the 6790 report from that are submitted by the residents case managers. On April 5, 2023, at 1:20 p.m., LALD-A stated the facility did not use an assisted living contract, which would have included the Right to Designate a Representative for Certain Purposes form. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 950		
01290 SS=I	144G.60 Subdivision 1 Background studies required	01290		

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01290	Continued From page 54 (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure a background study was conducted prior to staff providing services for one of one employee (unlicensed personnel (ULP)-D). This resulted in an immediate correction order on April 3, 2023, at approximately 7:30 p.m. Further, the licensee failed to maintain documentation of the background study for each paid employee, as required under section 144.057, for one of one employee (ULP-E). 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).	01290		

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	33425	A. BUILDING: _____ B. WING _____	04/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RESTFUL HOME LLC	1000 REANEY AVENUE SAINT PAUL, MN 55106

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01290	Continued From page 55 ULP-D ULP-D was hired November 15, 2022. On April 3, 2023, at 10:05 a.m., ULP-D was working alone at the facility as the evaluators entered the facility to begin the licensee's assisted living survey, ULP-D lacked an employee record and evidence of a completed background study clearance as required prior to providing services for the licensee's residents. ULP-D provided medication administration for R1, as indicated on R1's medication administration record (MAR) between March 1, 2023 through March 31, 2023. On April 3, 2023, at approximately 3:08 p.m., the NETStudy 2.0 website included a Background Study Notice dated December 6, 2022, indicating ULP-D had been disqualified and should be removed from direct resident care. On April 3, 2023 at 1:00 p.m., licensed assisted living director (LALD)-A indicated that he did not have the background study clearance, and ULP-D had the copy of her background study. LALD-A was unable to find ULP-D in NETStudy. On April 3, 2023, at approximately 5:31 p.m., LALD-A was not aware ULP-D had been disqualified. At 5:40 p.m., LALD-A accessed NETStudy a second time and acknowledged that ULP-D had been disqualified. The licensee's Personnel Records Policy dated June 1, 2010, indicated "Personnel records will be kept up-to-date, well organized and	01290		

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01290	Continued From page 56 confidential." and "2. The personnel records for each person will include: Criminal background study." No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE An immediate correction order was identified on April 3, 2023, at approximately 7:30 p.m., and issued for licensing order 1290 related to background studies. On April 5, 2023, at approximately 1:00 p.m., the immediacy of the correction order for 1290 was removed, the scope and level was unchanged. ULP-E ULP-E was hired April 25, 2022, and provided direct care services for the licensee's residents. On April 3, 2023, at 4:09 p.m., ULP-E was observed to administer medications to R3. ULP-E lacked an employee record and documentation of the completed background study clearance as required under section 144.057. On April 3, 2023, at 11:47 a.m., during the entrance conference, LALD-A stated the employee files were not yet completed. LALD-A stated he had background studies. No employee file or background study clearance form was provided. On April 3, 2023, at 1:13 p.m., LALD-A stated he had not accessed NETStudy to see the employee background studies. LALD-A added he did not have a copy of the employees' background study clearance forms on file.	01290		

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01290	Continued From page 57 On April 4, 2023, at 3:29 p.m., ULP-E stated she had a background study completed, and kept her own copy, which she showed the surveyors. The licensee's Personnel Records Policy dated June 1, 2010, indicated "Personnel records will be kept up-to-date, well organized and confidential." and "2. The personnel records for each person will include: Criminal background study." No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
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; (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;	01370		

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01370	Continued From page 58 (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 interview and record review, the licensee failed to ensure training and competency to include all required content was completed for two of two unlicensed employees, unlicensed personnel (ULP)-D and ULP-E. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-D and ULP-E were hired November 15, 2022, and April 25, 2022, respectively, and	01370		

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01370	Continued From page 59 provided direct cares for residents of the facility. ULP-D and ULP-E both lacked an employee record and documentation of training in the following topics: -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; -appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; -training on the prevention of falls; -standby assistance techniques and how to perform them; -medication, exercise, and treatment reminders; -basic nutrition, meal preparation, food safety, and assistance with eating; -preparation of modified diets as ordered by a licensed health professional; -communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; -awareness of confidentiality and privacy; -understanding appropriate boundaries between staff and residents and the resident's family; -procedures to use in handling various emergency situations; and -awareness of commonly used health technology equipment and assistive devices. On April 3, 2023, at 1:31 p.m., licensed assisted	01370		

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01370	Continued From page 60 living director (LALD)-A stated they had not developed a staff training procedure. LALD-A stated he trained staff on professional etiquette and interactions with residents, but there had not been any specific caregiver training from an RN. LALD-A further stated training was not documented. On April 4, 2023, at 10:07 a.m., registered nurse (RN)-B stated she had not overseen any training activities, and LALD-A was in charge of caregiver training. RN-B further stated she did not know where the training would be documented. The licensee's Competency Evaluation of Unlicensed Personnel policy, revised July 1, 2010, indicated, "A Registered Nurse will complete and document competency of unlicensed personnel prior to their delivery of services to a resident." The licensee's training policies did not reflect the requirements outlined in 144G Assisted Living statutes. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		
01380 SS=I	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to	01380		

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01380	Continued From page 61 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 facility failed to ensure training and competency evaluations were completed as required prior to providing direct care to residents for two of two unlicensed personnel (ULP)-D, ULP-E. This resulted in an immediate order identified on April 4, 2023, at approximately 2:45 p.m. 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). The findings include: ULP-E was hired April 25, 2022, and provided direct cares for residents of the facility. On April 3, 2023, at 4:09 p.m., ULP-E was observed to administer medications to R3. ULP-D was hired November 15, 2022, and	01380		

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01380	Continued From page 62 provided direct cares for residents of the facility. R1's medication administration record (MAR) from March of 2023 indicated ULP-D administered medications to R1 on the following dates: March 10, 13-16, 21-24, and 27-31, 2023. ULP-D and ULP-E's employee records lacked documentation of training and competency evaluation including: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. On April 3, 2023, at 1:20 p.m., ULP-H stated she planned to do a lot of the caregiver training. Although ULP-H further stated she would also be doing training on medication administration, ULP-H verified she did not hold a license as a registered nurse (RN). On April 3, 2023, at 1:31 p.m., licensed assisted living director (LALD)-A stated they had not developed a staff training procedure. LALD-A stated he trained staff on professional etiquette and interactions with residents, but there had not been any specific caregiver training from an RN. LALD-A further stated training was not documented. LALD-A further stated RN-B was	01380		

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01380	Continued From page 63 "supposed to educate" staff on medication administration, but was not sure if it was completed or where it would be documented. On April 4, 2023, at 10:07 a.m., RN-B stated she had not overseen any caregiver training activities. Although, RN-B stated she "verbally educated" unlicensed personnel on "document medication in RTASKS" in the electronic medical record, RN-B stated the training was not documented and competency of medication administration was not observed. The licensee's Delegated Nursing services policy dated July 1, 2010 (eleven years prior to 144G), indicated, "A Registered Nurse may delegate nursing services to unlicensed staff after: (1) Completing a nursing assessment of the client's functional status and need for nursing services; (2) Developing a service plan/ care plan for providing the services according to the client's needs and preferences; (3) Determining that the unlicensed person is trained and competent and has been instructed in the proper methods to perform the procedures with respect to the specific client; and (4) Including written instructions for performing the procedure for the client in the client's record. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE An immediate correction order was identified on April 4, 2023, at approximately 2:45 p.m., and issued for licensing order 1380 related to training and competency. On April 5, 2023, at approximately 1:00 p.m., the immediacy of the correction order for 1380 was removed, the scope and level was unchanged.	01380		

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01440 SS=F	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 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 a registered nurse (RN) conducted direct supervision of staff performing a delegated task within 30 days of providing services for two of two employees, unlicensed personnel (ULP)-D and ULP-E. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a	01440		

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01440	Continued From page 65 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-D and ULP-E were hired November 15, 2022, and April 25, 2022, respectively. Both employees lacked a personnel record and documentation of direct supervision of RN delegated tasks within 30 days of providing services. On April 3, 2023, at 11:05 a.m., ULP-D stated she did not know which medications residents were taking, she "just gives them". ULP-D stated she had in-person training with RN-B on medication administration and did a quiz. No documentation of training or 30-day supervision was provided. On April 3, 2023, at 1:31 p.m., licensed assisted living director (LALD)-A stated they had not yet developed a protocol for staff training. LALD-A further stated staff had training with LALD regarding topics such as professional etiquette, interactions with residents, and RN-B was responsible for educating staff regarding medication administration, but it was not documented. On April 4, 2023, at 12:27 p.m., ULP-E stated the previous RNs trained ULP-E prior to RN-B coming to the facility. ULP-E stated she had no additional training from RN-B and did not know if there was any documentation of her previous training. No documentation of training or 30-day supervision was provided. On April 4, 2023, at 10:07 a.m., RN-B stated	01440		

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01440	Continued From page 66 LALD-A was responsible for the 30-day supervisions of staff, and she was hired (July 28, 2022) for "medication set up and assessments" only. RN-B further stated she had not overseen any training activities, but did "verbally educate" staff on administering medications that she had set up, and documenting in the electronic medical record. RN-B further stated there was no documentation of the training provided. The licensee's Supervision of Unlicensed Personnel policy, revised July 1, 2010, indicated, "The RN will periodically supervise unlicensed personnel. This must be done within 14 days after initiation of home care services and at least every 62 days thereafter, or more frequently if indicated by a clinical assessment and the client's individual service plan. The purpose is to ensure that the work is being performed adequately, identify problems, and assess the appropriateness of the care to the client's needs." The licensee's supervision policy did not reflect the requirements outlined in 144G Assisted Living statutes. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01440		
01460 SS=F	144G.63 Subdivision 1 Orientation of staff and supervisors All staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. The orientation may be incorporated into the training required under subdivision 5. The	01460		

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01460	Continued From page 67 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 staff providing services completed orientation to assisted living facility licensing requirements and regulations, before providing services, for three of three employees, registered nurse (RN)-B, unlicensed personnel (ULP)-D, and ULP-E. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: RN-B, ULP-D and ULP-E were hired July 28, 2022, November 15, 2022, and April 25, 2022, respectively, and provided direct care services for the licensee's residents. RN-B, ULP-D and ULP-E lacked a personnel record and documentation of orientation, completed before providing services, including: - Overview of Assisted Living statutes; - Review of provider's policies and procedures; - Handling emergencies and using emergency services; - Home care/Assisted Living bill of rights - Handling of resident/clients' complaints, reporting of complaints, where to report	01460		

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01460	Continued From page 68 - Consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; - Review of types of Assisted Living services the employee will provide and provider's scope of license; and - Principles of person-centered planning/service delivery and how they apply to direct support services provided by the staff person. On April 3, 2023, at 12:45 p.m., licensed assisted living director (LALD)-A stated he did not have documentation that orientation was provided to staff. On April 3, 2023, at 1:31 p.m., LALD-A stated they had not yet developed a protocol for staff training. LALD-A further stated newly hired staff had one on one training with the LALD regarding topics such as professional etiquette, and interactions with residents, but he did not keep documentation. On April 4, 2023, at 10:04 a.m., ULP-E stated she had training on emergencies and "when to call the non-emergency number", but was not provided training on any policies, assisted living statutes and services, and was not familiar with the services of the ombudsman. On April 4, 2023, at 10:07 a.m., RN-B stated she had not been oriented to any assisted living statutes or policies, or emergency preparedness procedures. RN-B stated she was familiar with vulnerable adult and abuse reporting rules from her other job, but was not trained on it by the	01460		

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	33425	A. BUILDING: _____ B. WING _____	04/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01460	Continued From page 69 licensee. The licensee's Home Care Orientation policy, revised July 1, 2010 (eleven years prior to 144G), indicated, "All Class F Home Care employees, including those who provide direct care, who provide supervision of direct care, or who provide management services, must complete their orientation to home care requirements before providing home care services to clients." The policy further indicated, "At minimum, this orientation must include the following topics: ·An overview of Minnesota's home care law (MN Statutes 144A.43 to 144A.48) and rules (Part 4668), emphasizing the requirements applicable to the Class F Home Care License; ·Handling emergencies and using emergency services; ·Reporting the maltreatment of vulnerable minors or adults under Minnesota Statutes, sections 626.556 and 626.557; ·The home care bill of rights (MN Statute 144A.44); ·Handling clients' complaints and how clients and staff may report complaints to the Office of Health Facility Complaints; ·The services of the Ombudsman for Older Minnesotans and how to contact the Ombudsman's office." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01460		
01530 SS=F	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the	01530		

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01530	Continued From page 70 following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to ensure the required amount of dementia care training was completed in the required time frame in accordance with 144G.64 for three of three employees, (registered nurse (RN)-B, unlicensed personnel (ULP)-D, and ULP-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a	01530		

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01530	Continued From page 71 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: RN-B, ULP-D and ULP-E were hired July 28, 2022, November 15, 2022, and April 25, 2022, respectively, and provided direct care services for the licensee's residents. RN-B, ULP-D and ULP-E lacked a personnel record and documentation they completed at least eight hours of initial dementia care training on required topics within 120 working hours, including: (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. On April 3, 2023, at 1:31 p.m., LALD-A stated they had not yet developed a protocol for staff training. LALD-A further stated newly hired staff had one on one training with the LALD regarding topics such as professional etiquette, and interactions with residents, but he did not keep documentation. On April 4, 2023, at 10:04 a.m., ULP-E stated she did not recall completing any dementia care training. On April 4, 2023, at 10:07 a.m., RN-B stated she did not complete any dementia care training provided by the licensee. RN-B further stated she	01530		

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01530	Continued From page 72 had not overseen any training activities, and LALD-A was in charge of caregiver training, and she did not know where the training would be documented. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
01610 SS=I	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 interview and record review, the licensee failed to ensure a registered nurse (RN) completed an initial comprehensive nursing assessment prior to signing the assisted living contract/providing services for three of three	01610		

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01610	Continued From page 73 residents (R1, R2, R4). This resulted in an immediate correction order issued on April 3, 2023, at approximately 7:30 p.m. 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). The findings include: R2 On April 3, 2023, at 10:50 a.m. licensed assisted living director (LALD)-A stated R2 "just moved in on Friday (admitted)" March 31, 2023. R2 lacked an electronic medical record (EMR), including an initial RN assessment completed at the time of admission or prior to the initiation of services. On April 3, 2023, at 3:57 p.m., case worker (CW)-F stated he brought R2 to the licensee's facility approximately 11:30-11:45 a.m. R2 came to the facility with medications that were pre-set up in a medication box at another facility. CW-F stated unlicensed personnel (ULP)-D was present at the time R2 was brought to the facility. CW-F further stated LALD-A was not present, but CW-F called and notified LALD-A when he returned to his office approximately 12:00 p.m., on March 31, 2023. On April 3, 2023, at 3:58 p.m., RN-B was	01610		

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01610	Continued From page 74 interviewed by phone. RN-B stated she had not been made aware of R2's admission until ULP-D notified her by phone, that R2 had arrived at the facility, on Friday March 31, 2023. RN-B stated she worked the weekend at her "full time" job and was "unable to leave" the other job to assess R2. RN-B further stated they were only scheduled Monday thru Wednesday at the licessnee. RN-B stated she would not be at the assisted living facility Thursday and Fridays; but was "on call." RN-B confirmed she had not been to the facility since R2 was admitted. RN-B stated she was not notified R2 had medications at the time of admission. RN-B verified an initial assessment should have been completed. On April 3, 2023, at 5:42 p.m. LALD-A stated he contacted RN-B at 11:48 a.m. (March 31, 2023), letting her know R2 was brought to the facility. LALD-A stated RN-B told him she would not be available to see R2 that day, but would come after the weekend, on Monday or Tuesday (3 or 4 days after admission). R1 R1 was admitted March 9, 2023, and received services including assistance with medication administration. R1's record lacked an initial RN assessment completed at admission or prior to the initiation of services. R4 R4 was admitted January 30, 2023, and received services including assistance with medication administration. R4's record lacked an initial RN assessment completed at admission or prior to the initiation of	01610		

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01610	Continued From page 75 services. On April 3, 2023 at 4:52 p.m., RN-B stated the RN assessment had not been completed for R1 and R4. The licensee's Admission Assessment policy dated June 1, 2010 (prior to issuance of 144G in 2021), indicated a nursing assessment would be completed by the registered nurse. The policy further indicated the information gathered would be used to develop a service plan / care plan before unlicensed staff provided any delegated nursing services. No additional information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE An immediate correction order was identified on April 3, 2023, at approximately 7:30 p.m., and issued for licensing order 1610 related to initial assessment. On April 5, 2023, at approximately 1:00 p.m., the immediacy of the correction order for 1610 was removed, the scope and level was unchanged.	01610		
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	01620		

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01620	Continued From page 76 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 interview, and record review, the licensee failed to ensure a registered nurse (RN) conducted ongoing resident monitoring and reassessment 14 calendar days from the initial assessment, and not to exceed 90 calendar days from the previous assessment for two of two residents (R1, R3) with records reviewed. 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 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). R1 R1's record lacked evidence of monitoring and reassessment within 14 days from the start of services.	01620		

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01620	Continued From page 77 R1 was admitted March 1, 2023, and had diagnoses including lumbago (low back pain), major depression and diabetes. R1's record indicated R1 received services including, assistance with housekeeping and medication administration. On April 4, 2023, at 2:55 p.m., RN-B acknowledged that both the initial assessment and the assessment within 14 days of start of services had not yet been completed on R1. R3 R3's record lacked evidence of monitoring and reassessment within 14 days of start of services and subsequent assessment not to exceed 90 days from the previous assessment. R3 was admitted June 9, 2022, and had diagnoses including polysubstance abuse, cognitive deficit, and schizoaffective disorder (a mental disorder characterized by abnormal thought processes and an unstable mood). R3's record indicated R3 received services including assistance with activities of daily living (ADLs), toileting, housekeeping, meals, laundry, and medication administration. R3's record included an initial assessment completed September 21, 2022, and a subsequent assessment completed January 20, 2023, 122 days after the previous assessment. On April 4, 2023, at 2:55 p.m., RN-B stated a 14-day assessment had not been completed for R3. RN-B indicated that she was not aware that an assessment needed to be completed within 14 days of start of services. RN-B stated that an	01620		

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01620	Continued From page 78 assessment was completed on R3 as soon as it was identified that the initial assessment was not completed. RN-B further acknowledged that more than 90 days had passed since R3's latest assessment completed on January 20, 2023. The licensee's Admission Assessment - Resident policy, dated July 1, 2010, included, " A Registered Nurse will complete a nursing assessment of a client and will use it to develop a service plan before unlicensed personnel provide any delegated nursing services, including medication assistance or administration or central storage of medications." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01630 SS=I	144G.70 Subd. 3 Temporary service plan When a facility initiates services and the individualized assessment required in subdivision 2 has not been completed, the facility must complete a temporary plan and agreement with the resident for services. A temporary service plan shall not be effective for more than 72 hours. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to initiate a temporary service plan as required, for one of one resident (R2). This resulted in an immediate correction order issued on April 4, 2023, at approximately 2:45 p.m.	01630		

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01630	Continued From page 79 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). Findings include: On April 3, 2023, at 10:50 a.m., licensed assisted living director (LALD)-A stated R2 "just moved in on Friday (admitted)" March 31, 2023. On April 3, 2023, at 2:09 p.m., the surveyor observed unlicensed personnel (ULP)-D's process to provide medications to R2. ULP-D showed surveyor R2's medication set up box that was provided by R2's case worker (CW)-F when R2 was brought to the facility on March 31, 2023. The medication set up box had no pills in the a.m. or p.m. boxes for Friday, Saturday, Sunday, Wednesday and Thursday. Monday medication set up box had medications in the a.m. and p.m. boxes. ULP-D stated that she administered R2's a.m. medications on Monday. ULP-D stated she did not know why the Monday a.m. box still had pills in it. R2 was present during this interview, and indicated he did take a.m. medications given to him by ULP-D. Tuesday's medication set up box had no pills in a.m. box and did have pills in p.m. box. In addition, ULP-D stated she had not been able to document the medication administration since March 31,2023, due to R2's medication administration record (MAR) not created yet in electronic medical record. R2 lacked a resident record and temporary plan	01630		

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01630	Continued From page 80 and agreement with the resident for services. On April 3, 2023, at 12:08 p.m., LALD-A stated they did not have a service plan for residents, but used the "6970 form". They determined services needed by using that document. LALD-A stated they did not have the resident sign any kind of agreement for services, and they knew the services to be provided because they talked about it with the resident during the pre-assessment. LALD-A further stated staff knew what services to provide using the list in the electronic medical record and the staff documented the tasks completed or refused in the electronic medical record. On April 3, 2023, at 12:17 p.m., LALD-A stated the residents signed an agreement on rent and they did not keep any paper documents. LALD-A stated they did not have an assisted living contract. On April 3, 2023, at 2:03 p.m., LALD-A stated R2 might need assistance with blood glucose testing, but was not sure, because registered nurse (RN)-B had not yet entered him into the electronic medical record (EMR). On April 4, 2023, at 10:07 a.m., RN-B stated that she did not create a resident service plan. RN-B stated that LALD-A completed all service plans for the residents. On April 4, 2023, at 11:45 a.m., R2 stated LALD-A verbally discussed the services that would provided. R2 was not provided with or signed any written document of the services licensee would provide. R2 stated, "He told me how much the rent was, and I paid it."	01630		

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01630	Continued From page 81 Licensee's Service Plan policy, dated June 1, 2010, indicated "All Class F Home Care services will be provided in accordance with a suitable and up-to-date written service plan, signed by the resident or the resident's responsible person and; 1. The RN will establish, with the resident or the resident's responsible person, a service plan or agreement for providing Class F Home Care services in accordance with the accepted standards of practice for professional nursing. This service plan is an agreement between the provider and the resident and will provide the resident with adequate information about the services they are receiving and the charges that they are accruing. 2. The service plan will be completed by the RN as soon as possible and no later than two weeks after the initiation of assisted living home care services to a resident. The RN must complete the service plan before any delegated nursing services are initiated. 3. The service agreement will be signed by the resident or the resident's responsible other at the time it is initiated, and each time any modifications are made." No further information provided. TIME PERIOD FOR CORRECTION: IMMEDIATE An immediate correction order was identified on April 4, 2023, at approximately 2:45 p.m., and issued for licensing order 1630 related to initial service plan. On April 5, 2023, at approximately 1:00 p.m., the immediacy of the correction order for 1630 was removed, the scope and level was unchanged.	01630		
01640 SS=F	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to	01640		

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RESTFUL HOME LLC	1000 REANEY AVENUE SAINT PAUL, MN 55106

(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
01640	Continued From page 82 (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. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to finalize a current written service plan within 14 calendar days for two of two residents (R1, 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) 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).	01640		

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01640	Continued From page 83 The findings include: R1 R1 had diagnoses including, lumbago (low back pain), major depression and diabetes. R1's record indicated R1 received services including assistance with housekeeping and medication administration. R3 R3 had diagnoses including, polysubstance abuse, cognitive deficit, and schizoaffective disorder (a mental disorder characterized by abnormal thought processes and an unstable mood). R3's record indicated R3 received services including assistance with activities of daily living (ADLs), toileting, housekeeping, meals, laundry, and medication administration. R1 and R3's records lacked a signed service plan with the required content, developed prior to the initiation of services. On April 4, 2023, during a 10:45 a.m. interview, R3 stated he did not recall reviewing or signing service plan for the care and fees associated with the licensee. On April 3, 2023, at 12:08 p.m., licensed assisted living director (LALD)-A stated they did not have a service plan, but use the "6970 form" to determine the services needed. LALD-A stated they did not have the resident sign any kind of agreement for services, and they knew the services to be provided because they talked about it during the pre-assessment. LALD-A further stated staff knew what services to provide	01640		

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01640	Continued From page 84 using the task list in the electronic medical record (EMR) and the staff documented the tasks completed or refused in the EMR. On April 3, 2023, at 12:17 p.m., LALD-A stated the residents signed an agreement on rent and he did not keep any paper documents. LALD-A stated they did not have an assisted living contract. On April 4, 2023, at 10:07 a.m., registered nurse (RN)-B stated that she did not create the resident service plan. RN-B stated that LALD-A completed all service plans for the residents. The Licensee's Service Plan policy, dated July 1, 2010, included "All Class F Home Care services will be provided in accordance with a suitable and up-to-date written service plan, signed by the resident or the resident's responsible person." and "2. The service plan will be completed by the RN as soon as possible and no later than two weeks after the initiation of assisted living home care services to a resident. The RN must complete the service plan before any delegated nursing services are initiated; 3. The service agreement will be signed by the resident or the resident's responsible other at the time it is initiated, and each time any modifications are made; 4. The Service Plan/Agreement will include; A. A specific description of the services and their frequency unique to each resident; B. The identification of the person or persons or categories of persons who are to provide the service; C. The schedule of the RN supervisory visits and any LPN monitoring visits; and D. The fee for services provided."	01640		

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01640	Continued From page 85 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01640		
01690 SS=I	144G.71 Subdivision 1 Medication management services (a) This section applies only to assisted living facilities that provide medication management services. (b) An assisted living facility that provides medication management services must develop, implement, and maintain current written medication management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse, licensed health professional, or pharmacist consistent with current practice standards and guidelines. (c) The written policies and procedures must address requesting and receiving prescriptions for medications; preparing and giving medications; verifying that prescription drugs are administered as prescribed; documenting medication management activities; controlling and storing medications; monitoring and evaluating medication use; resolving medication errors; communicating with the prescriber, pharmacist, and resident and legal and designated representatives; disposing of unused medications; and educating residents and legal and designated representatives about medications. When controlled substances are being managed, the policies and procedures must also identify how the provider will ensure security and accountability for the overall management, control, and disposition of those	01690		

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01690	Continued From page 86 substances in compliance with state and federal regulations and with subdivision 23. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to implement current medication management policies and procedures, which were developed under the supervision and direction of a registered nurse (RN)-B, consistent with current practice standards and guidelines related to medication management, delegation and pain management. The deficient practice affected two of two residents (R1, R2). This resulted in an immediate correction order issued on April 4, 2023, at approximately 2:45 p.m. 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). The findings include: AVAILABILITY OF RN RN-B was hired July 28, 2022, and provided supervisory and direct care services to the residents of the facility and to perform all nursing tasks. RN-B simultaneously held a nursing position working a full-time schedule, on night shift, at a hospital which would not allow her to be available to leave to address facility emergencies	01690		

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01690	Continued From page 87 or concerns. TRAINING Unlicensed personnel (ULP)-E was hired April 25, 2022, and provided direct cares for residents of the facility. On April 3, 2023, at 4:09 p.m., ULP-E was observed to administer medications to R3. ULP-D was hired November 15, 2023, and provided direct cares for residents of the facility. R1's medication administration record (MAR) from March of 2023 indicated ULP-D administered medications to R1 on the following dates: March 10, 13-16, 21-24, and 27-31, 2023. ULP-D and ULP-E's employee records lacked documented evidence of RN training and competency evaluation for medication administration. On April 3, 2023, at 1:36 p.m., licensed assisted living director (LALD)-A stated ULP-D had been trained regarding following the directions in the electronic medical record for medication administration, but no medication administration training or competency had been documented. On April 3, 2023, at approximately 2:09 p.m., the surveyor observed ULP-D's process used to provide medications to R2. ULP-D showed surveyor R2's medication set up box that was given to facility when R2 was dropped off by R2's case worker (CW)-F on March 31, 2023. The medication set up box had no pills in the a.m. or p.m. boxes for Friday, Saturday, Sunday, Wednesday and Thursday. Monday medication	01690		

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01690	Continued From page 88 set up box had medications in the a.m. and p.m. boxes. ULP-D stated that she administered R2's a.m. medications Monday. ULP-D stated she did not know why the Monday a.m. box still had pills in it. R2 was present during this interview, and indicated he did take the a.m. medications given to him by ULP-D. Tuesday's medication set up box had no pills in the a.m. box and did have pills in p.m. box. In addition, ULP-D stated she had not been able to document the medication administration since March 31,2023, due to R2's medication administration record (MAR) not created yet in electronic medical record. On April 4, 2023, at 12:27 p.m., ULP-E stated she was trained on medication administration by the RN that worked at the facility prior to RN-B, but was not sure where the documentation of that training would be. On April 3, 2023, at 1:20 p.m., ULP-H stated she planned to do a lot of the caregiver training. Although ULP-H further stated she would also be doing training on medication administration, ULP-H verified she did not hold a license as a registered nurse (RN). On April 3, 2023, at 1:31 p.m., LALD-A stated they had not developed a staff training procedure. LALD-A stated he trained staff on professional etiquette and interactions with residents, but there had not been any specific caregiver training from an RN. LALD-A further stated training was not documented. LALD-A further stated RN-B was "supposed to educate" staff on medication administration, but was not sure if it was completed or where it would be documented. On April 4, 2023, at 10:07 a.m., RN-B stated she	01690		

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01690	Continued From page 89 had not overseen any caregiver training activities. Although, RN-B stated she "verbally educated" unlicensed personnel on "document medication in RTASKS" in the electronic medical record, RN-B stated the training was not documented and competency of medication administration was not observed. MEDICATION ASSESSMENT R2 On April 3, 2023, at 10:50 a.m., LALD-A stated R2 "just moved in on Friday (admitted)" March 31, 2023. On April 3, 2023 at 2:55 p.m., ULP-D stated R2's medications were delivered in a medication set up box and was provided to the facility by CW-F when R2 was dropped off at the facility on "Friday (March 31, 2023)." ULP-D stated the medications arrived with the resident had been administered since March 31, 2023 but had not been documented. R1 R1 was admitted March 9, 2023 and received services including assistance with medication administration. R1 and R2's record lacked documentation of a medication assessment and medication management plan completed at the time of admission or prior to the initiation of medication management services. On April 3, 2023 at 3:58 p.m., RN-B stated (via phone) she worked at the hospital this last weekend so she wasn't able to leave her job to get R2's assessment completed. RN-B stated R2's medications "haven't been reviewed yet." When further asked about the process for	01690		

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01690	Continued From page 90 medication assessment, RN-B stated they did not complete a medication assessment. The licensee's Medication Administration - Delegation policy dated June 1, 2010 (eleven years prior to 144G), indicated, "A person, who satisfies the requirements and has been delegated the responsibility by the RN, may administer medications, orally, by suppository, through eye drops, through ear drops, by use of inhalant or topically. 1. The unlicensed person who satisfies the training requirements for assistance with self-administration of medication administration may perform assistance if: A. Before performing the procedures, the person is instructed by the RN the proper methods to perform the procedures with respect to each client; B. The RN specifies in writing specific instruction for performing the procedures for each client; C. Before performing the procedures, the person demonstrates to the RN the person's ability to perform the procedures for each client; D. The procedures for each client are documented in the clients' records and; E. The assisted living home care provider licensee retains documentation by the RN regarding the person's demonstrated competency. 2. Documentation is retained in the personnel records of the unlicensed personnel who have satisfied the above training requirements." No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE An immediate correction order was identified on April 4, 2023, at approximately 2:45 p.m., and	01690		

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01690	Continued From page 91 issued for licensing order 1690 related to medication management. On April 5, 2023, at approximately 1:00 p.m., the immediacy of the correction order for 1690 was removed, the scope and level was unchanged.	01690		
01710 SS=E	144G.71 Subd. 3 Individualized medication monitoring and reas The assisted living facility must monitor and reassess the resident's medication management services as needed under subdivision 2 when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually. 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) monitored and reassessed the resident receiving medication management services as needed when the resident presents with symptoms other issues that may be medication-related and, at a minimum, annually, for two of two residents (R1, 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) 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:	01710		

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01710	Continued From page 92 R1 R1 was admitted March 9, 2023, and had diagnoses including lumbago (low back pain), major depression and diabetes. R1's record indicated R1 received services, including assistance with medication management. R1's medication administration record (MAR) for March and April 2023, indicated R1 received daily assistance with medication administration from March 10, 2023 through April 2, 2023. R1's record lacked a medication assessment completed upon admission. R1's nursing assessment, dated April 3, 2023, lacked a review of medications and was completed after survey was initiated on April 3, 2023. R1's electronic nursing progress notes were reviewed. The provided documentation lacked evidence the RN conducted a review of all medications the resident was known to be taking to include a review of the side effects and contraindications. R3 R3 was admitted June 9, 2022, and had diagnoses including. polysubstance abuse, cognitive deficit, and schizoaffective disorder (a mental disorder characterized by abnormal thought processes and an unstable mood). R3's record indicated R3 received services including assistance with medication management.	01710		

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01710	Continued From page 93 On April 3, 2023, at 4:09 p.m., ULP-E was observed to administer medications to R3. On April 3, 2023, at 3:58 p.m., RN-B stated medication assessments or medication management plans had not been completed for R1 or R3. RN-B indicated that when there are new medication orders for a resident, they would get updated in the electronic medical record. RN-B acknowledged that medication assessments had not been completed on the residents and RN-B noted, she was not aware this was required. The licensee's Admission Assessment - Resident policy dated, July 1, 2010, included "A Registered Nurse will complete a nursing assessment of a client and will use it to develop a service plan before unlicensed personnel provide any delegated nursing services, including medication assistance or administration or central storage of medications." and "3. For a client who will receive assistance with self-administration of medication or medication administration or central storage, the RN assessment will include the need for assistance with medication assistance or administration." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01710		
01730 SS=E	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	01730		

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01730	Continued From page 94 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 medication management. This MN Requirement is not met as evidenced by:	01730		

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01730	Continued From page 95 Based on observation, interview and record review, the licensee failed to develop and maintain a current individualized medication management plan to include all required content for two of two residents (R1, R3) with records reviewed. 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 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 had diagnoses including lumbago (low back pain), major depression and diabetes. R1's record indicated R1 received services, including medication management. R1's medication administration record (MAR) for March and April 2023, indicated R1 received daily assistance with medication administration March 10 through April 2, 2023. R3 R3 had diagnoses including polysubstance abuse, cognitive deficit, and schizoaffective disorder (a mental disorder characterized by abnormal thought processes and an unstable mood). R3's record indicated R3 received services, including medication management.	01730		

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01730	Continued From page 96 On April 3, 2023, at 4:09 p.m., ULP-E was observed to administer medications to R3. R1 and R3's records lacked a medication management plan including the following: -statement describing the medication management services that will be provided; -description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; -documentation of specific resident instructions relating to the administration of medications; -identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; -identification of medication management tasks that may be delegated to unlicensed personnel; -procedures for staff notifying a registered nurse (RN) or appropriate licensed health professional when a problem arose with medication management services; and -any resident-specific requirements relating to documentation of medication administration, verifications that all medications are administered as prescribed and monitoring of medication use to prevent possible complications or adverse reactions. On April, 3, 2023, at 3:58 p.m., RN-B stated R1 and R3 both lacked a medication management plan with the required content. On April 4, 2023, at 3:07 p.m., RN-B stated she was not sure who would be responsible for ensuring residents had current medication orders. RN-B further stated the pharmacy service would update her if there were any changes to medications.	01730		

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01730	Continued From page 97 The licensee's Admission Assessment - Resident policy dated, July 1, 2010, included "A Registered Nurse will complete a nursing assessment of a client and will use it to develop a service plan before unlicensed personnel provide any delegated nursing services, including medication assistance or administration or central storage of medications." and "3. For a client who will receive assistance with self-administration of medication or medication administration or central storage, the RN assessment will include the need for assistance with medication assistance or administration." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01760 SS=E	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced	01760		

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01760	Continued From page 98 by: Based on observation, interview, and record review, the licensee failed to ensure medications were administered per physician's orders for three of three residents (R1, R2, 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) 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). Findings include: R2 On April 3, 2023, at 10:50 a.m. licensed assisted living director (LALD)-A stated R2 "just moved in on Friday (admitted)" March 31, 2023, and had not been entered into the electronic medical record (EMR). On April 3, 2023, at 2:09 p.m., the surveyor observed unlicensed personnel (ULP)-D's process used to provide medications to R2. ULP-D stated R2 came with medications that were already set up in a medication box. ULP- further stated she administered the medications as they were set up, but had not been able to document the medication administration since March 31, 2023, because R2's medication administration record (MAR) had not been created in the EMR. R2's medication box included an undated form with information including R2's name and date of birth that read,	01760		

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01760	Continued From page 99 "Current Medication List: Olanzapine 5 [milligrams (mg)] - AM Pioglitazone 30mg - AM Naltrexone 25mg- AM (Takes half of a 50mg tablet) Citalopram 10mg - AM Glipizide ER 10mg- Morning and Night Naproxen 500mg - Morning and Night Atorvastatin 40mg - Night Olanzapine 15mg- Night Albuterol Inhaler - 2 puffs every four hours as needed" The form further indicated, in a handwritten note added at the bottom of the list, "*Fiber supplement recommended by his doctor" R2's record lacked documentation of administration of the above listed medications. On April 3, 2023, at 6:57 p.m., registered nurse (RN)-B stated she had not created an EMR for R2 and was not aware of the medications R2 was taking until today (Monday 4/3). R1 R1 had diagnoses including, lumbago (low back pain), major depression and diabetes. R1's record indicated R1 received services including assistance with meals, housekeeping, laundry, and medication administration. R1's record included a MAR for March and April 2023. The MAR indicated R1 was assisted with medication administration March 10-31, 2023, and April 1-2, 2023. R1's MAR lacked documentation of administration or why medications were not administered at the following scheduled times:	01760		

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01760	Continued From page 100 -amlodipine (for blood pressure) 10 mg, Take 1 tablet (10 mg) by mouth once daily; March 18, 30 at 9:00 a.m.; -aspirin 81 mg, Take 1 tablet (81 mg) by mouth once daily with a meal; March 18, 30 at 9:00 a.m.; -Byetta (for diabetes) 5 micrograms (mcg)/dose, Inject 5 mcg subcutaneous 2 times before meal; March 18, 30 at 9:00 a.m.; -Centrum Silver Tablet (multivitamin supplement), Take 1 tablet by mouth once daily; March 18, 30 at 9:00 a.m.; -furosemide (for edema/fluid retention) 20 mg Take 1 tablet (20 mg) by mouth every morning; March 18, 30 at 9:00 a.m.; -losartan (for blood pressure) 50 mg Take 1 tab (50 mg) by mouth once daily; March 18, 30 at 9:00 a.m.; -metoprolol Succinate (for blood pressure) 50 mg Take 1 tablet (50 mg) by mouth daily; March 18, 30 at 9:00 a.m.; -tamsulosin (for urinary health) 0.4 mg Take 1 capsule (0.4 mg) by mouth once daily with meal; March 18, 30, at 9:00 a.m.; and -insulin glargine (long-acting insulin, for diabetes)100 unit/1milliliter (ml) insulin pen, inject 25 units subcutaneous once daily at noon; March 18, 30 at 12:00 p.m. R3 R3 had diagnoses including, substance abuse and schizoaffective disorder (a mental disorder characterized by abnormal thought processes and an unstable mood). R3's record indicated R3 received services including assistance with activities of daily living (ADLs), housekeeping, laundry, and medication administration. On April 3, 2023, at 4:08 p.m., ULP-E	01760		

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01760	Continued From page 101 administered medications to R3. Medications for R3 were observed set up in small plastic bags in drawers labeled for each scheduled administration time. ULP-E stated RN-B set up residents' medications in advance and ULP-E gave them to the resident. R3's record included a MAR for March and April 2023. The MAR indicated R3 was assisted with medication administration March 1-31, 2023, and April 1-3, 2023. R3's MAR lacked documentation of administration or why medications were not administered at the following scheduled times: -amlodipine 10 mg, 1 tablet (10 mg) by mouth daily with meal; March 4, 6, 7, 18, and April 3 at 8:00 a.m.; -aspirin 81 mg, 1 tablet by mouth daily with meal; March 4, 6, 7, 18, and April 3 at 8:00 a.m.; -atorvastatin calcium (for cholesterol) 40 mg, 1 tablet by mouth daily with meal; March 4, 6, 7, 18, and April 3 at 8:00 a.m.; -carvedilol (for blood pressure) 25 mg, 1 tablet by mouth two times a day; March 4, 6, 7, 18, and April 3 at 8:00 a.m. and March 4 and 6 at 8:00 p.m.; -certavite senior (multi-vitamin supplement) .4 mg-300 microgram (mcg)-250 mcg, 1 tablet by mouth daily; March 4, 6, 7, 18, and April 3 at 8:00 a.m.; -clopidogrel (blood thinner) 75 mg, 1 tablet by mouth every morning; March 4, 6, 7, 18, and April 3 at 8:00 a.m.; -furosemide 20 mg 1 tablet by mouth daily; March 4, 6, 7, 18, and April 3 at 8:00 a.m.; -gabapentin (for pain) 600 mg, 1 tablet by mouth three times daily; March 4, 6, 7, 18, and April 3 at 8:00 a.m., and March 4 and 6 at 4:00 p.m. and 8:00 p.m.;	01760		

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01760	Continued From page 102 -hydralazine hydrochloride (for blood pressure) 25 mg, take 2 tablets by mouth 3 times a day; March 4, 6, 7, 18, and April 3 at 8:00 a.m. and March 4 and 6 at 4:00 p.m. and 8:00 p.m; -isosorbide mononitrate ER [extended release] (for chest pain) 60 mg, 1 tablet by mouth daily; March 4, 6, 7, 18, and April 3 at 8:00 a.m.; -levothyroxine sodium (for thyroid) 25 mcg, 1 tablet by mouth daily before breakfast; March 4, 6, 7, 18, and April 3 at 8:00 a.m.; -lisinopril (for blood pressure) 40 mg, 1 tablet by mouth daily; March 4, 6, 7, 18, and April 3 at 8:00 a.m.; -spironolactone (for plood pressure) 50 mg, 1 tablet by mouth every morning; March 4, 6, 7, 18, and April 3 at 8:00 a.m.; -vitamin B-1 (supplement) 50 mg, 1 tablet by mouth daily; March 4, 6, 7, 18, and April 3 at 8:00 a.m.; -vitamin B-12 (supplement) 1000 mcg, 1 tablet by mouth daily; March 4, 6, 7, 18, and April 3 at 8:00 a.m.; -latanoprost (for glaucoma) 0.005% drops, instill 1 drop in both eyes every bedtime; March 4 and 6 at 8:00 p.m. On April 4, 2023, at 10:07 a.m., RN-B stated she did "verbally educate" staff on giving meds that were set up. RN-B stated that verbal training included how to document the medication administration in the EMR. On April 5, 2023, at 10:24 a.m., RN-B stated ULPs should be documenting every day on medication administration. RN-B further stated if the resident was out of the building and unavailable, that code should be documented. The licensee's Documentation of Medication Reminders, Assistance, and Administration	01760		

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01760	Continued From page 103 policy, revised July 1, 2010, indicated, "Documentation of a medication reminder, medication assistance or medication administration will be completed immediately after that task has been performed." The policy further indicated, "Staff will chart in each resident's medication administration record any problems with medication administration, including refusals." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01770 SS=I	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure documentation of medication setup included all the required content for two of two residents (R2, R3). This had the potential to affect all eight licensee residents. This resulted in an immediate order identified on April 4, 2023, at approximately 2:45 p.m. 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,	01770		

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01770	Continued From page 104 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). The findings include: R2 On April 3, 2023, at 10:50 a.m. licensed assisted living director (LALD)-A stated R2 "just moved in on Friday (admitted)" March 31, 2023. On April 3, 2023, at 11:45 a.m., during the entrance conference, LALD-A stated registered nurse (RN)-B set up the residents medications for administration by the unlicensed personnel (ULP), and ULPs documented medication administration by checking the box in the electronic record indicating the medication was given. On April 3, 2023, at approximately 2:09 p.m., the surveyor observed ULP-D's process used to provide medications to R2. ULP-D showed surveyor R2's medication set up box that was given to facility when R2 was dropped off by R2's case worker (CW)-F on March 31, 2023. The medication set up box had no pills in the a.m. or p.m. boxes for Friday, Saturday, Sunday, Wednesday and Thursday. Monday medication set up box had medications in the a.m. and p.m. boxes. ULP-D stated that she administered R2's a.m. medications Monday. ULP-D stated she did not know why the Monday a.m. box still had pills in it. R2 was present during this interview, and indicated he did take the a.m. medications given to him by ULP-D. Tuesday's medication set up box had no pills in the a.m. box and did have pills	01770		

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01770	Continued From page 105 in p.m. box. In addition, ULP-D stated she had not been able to document the medication administration since March 31,2023, due to R2's medication administration record (MAR) not created yet in electronic medical record. On April 3, 2023, at 6:57 p.m., registered nurse (RN)-B stated she was not aware of what medications R2 was taking until "today (Monday 4/3)". R3 R3 was admitted June 9, 2022, and received services including assistance with medication administration. On April 3, 2023, at 4:08 p.m., ULP-E administered medications to R3. Medications for R3 were observed set up in small plastic bags in drawers labeled for each scheduled administration time. ULP-E stated RN-B set up residents' medications in advance and ULP-E administred them to the resident. R3's medication administration record for March 1 through April 4, 2023, indicated R3 was administered medications on the following dates: March 1-3, 5, 8-17, 19-31, and April 1, 2, and 4, 2023. R2 and R3's records lacked documentation of medication set up including dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup. On April 4, 2023, at 10:07 a.m., RN-B stated she was hired by the licensee for "medication set up and assessments". RN-B stated she did not	01770		

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01770	Continued From page 106 document setting up the residents' medications. RN-B added she documented in a progress note when she assisted one resident (R5) to set up her own medications, but did not document anything related to the medication set up for any other residents. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE An immediate correction order was identified on April 4, 2023, at approximately 2:45 p.m., and issued for licensing order 1770 related to documentation of medication set-up. On April 5, 2023, at approximately 1:00 p.m., the immediacy of the correction order for 1770 was removed, the scope and level was unchanged.	01770		
01820 SS=E	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure written or electronically recorded prescriptions were obtained for two of three residents (R2, 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) and was issued at a pattern scope (when more than a limited number	01820		

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01820	Continued From page 107 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: R2 On April 3, 2023, at 10:50 a.m. licensed assisted living director (LALD)-A stated R2 "just moved in on Friday (admitted)" March 31, 2023. On April 3, 2023, at 2:03 p.m., LALD-A stated registered nurse (RN)-B had not yet entered R2 into the electronic medical record (EMR). LALD-A further stated R2 was dropped off at the facility by his case manager with medications, but did not have prescriber orders. On April 3, 2023, at 2:08 p.m., unlicensed personnel (ULP)-D stated R2 came with medications that were already set up in a medication box. ULP- further stated she administered the medications as they were set up, but did not document the medication administration. R2's medication box included an undated form with information including R2's name and date of birth that read, "Current Medication List: Olanzapine 5 [milligrams (mg)] - AM Pioglitazone 30mg - AM Naltrexone 25mg- AM (Takes half of a 50mg tablet) Citalopram 10mg - AM Glipizide ER 10mg- Morning and Night Naproxen 500mg - Morning and Night Atorvastatin 40mg - Night Olanzapine 15mg- Night	01820		

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01820	Continued From page 108 Albuterol Inhaler - 2 puffs every four hours as needed" The form further indicated a note, handwritten at the bottom of the list, "*Fiber supplement recommended by his doctor" R2's record lacked signed prescriber orders for the above listed medications. On April 3, 2023, at 6:57 p.m., RN-B stated she was not aware of what medications ULPs were administering to R2 until "today (Monday 4/3)". R3 R3 had diagnoses including polysubstance abuse, cognitive deficit, and schizoaffective disorder (a mental disorder characterized by abnormal thought processes and an unstable mood). R3 received services including assistance with medication administration. On April 3, 2023, at 4:08 p.m., ULP-E administered medications to R3. Medications for R3 were observed set up in small plastic bags in drawers labeled for each scheduled administration time. ULP-E stated RN-B set up residents' medications in advance and ULP-E administered to the resident. R3's medication administration record (MAR) for April 2023, indicated R3 was administered the following scheduled medications: -amlodipine (for blood pressure, angina) 10 milligrams (mg), 1 tablet (10 mg) by mouth daily with meal; April 1-2, 4 at 8:00 a.m.; -aspirin (for heart health) 81 mg, 1 tablet by mouth daily with meal; April 1-2, 4, 8:00 a.m.; -atorvastatin calcium (for cholesterol) 40 mg, 1	01820		

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01820	Continued From page 109 tablet by mouth daily with meal; April 1, 2, 4 at 8:00 a.m.; -carvedilol (for blood pressure) 25 mg, 1 tablet by mouth two times a day; April 1-2 at 8:00 a.m. and 8:00 p.m., April 3 at 8:00 p.m., and April 4 at 8:00 a.m.; -certavite senior (multi-vitamin supplement) .4 mg-300 microgram (mcg)-250 mcg, 1 tablet by mouth daily; April 1, 2, 4 at 8:00 a.m.; -clopidogrel (blood thinner) 75 mg, 1 tablet by mouth every morning; April 1, 2, 4 at 8:00 a.m.; -furosemide (for water retention) 20 mg 1 tablet by mouth daily; April 1, 2, 4 at 8:00 a.m.; -gabapentin (for pain) 600 mg, 1 tablet by mouth three times daily; April 1-2 at 8:00 a.m., 4:00 p.m., and 8:00 p.m., April 3 at 4:00 p.m., and 8:00 p.m., and April 4 at 8:00 a.m.; -hydralazine hydrochloride (for blood pressure) 25 mg, take 2 tablets by mouth 3 times a day; April 1-2 at 8:00 a.m., 4:00 p.m., and 8:00 p.m., April 3 at 4:00 p.m., and 8:00 p.m., and April 4 at 8:00 a.m.; -isosorbide mononitrate ER [extended release] (for chest pain) 60 mg, 1 tablet by mouth daily; April 1, 2, 4 at 8:00 a.m.; -levothyroxine sodium (for thyroid) 25 mcg, 1 tablet by mouth daily before breakfast; April 1, 2, 4, 8:00 a.m.; -lisinopril (for blood pressure) 40 mg, 1 tablet by mouth daily; April 1, 2, 4, 8:00 a.m.; -spironolactone (for plood pressure) 50 mg, 1 tablet by mouth every morning; April 1, 2, 4, 8:00 a.m.; -vitamin B-1 (supplement) 50 mg, 1 tablet by mouth daily; April 1, 2, 4, 8:00 a.m.; -vitamin B-12 (supplement) 1000 mcg, 1 tablet by mouth daily; April 1, 2, 4, 8:00 a.m.; -latanoprost (for glaucoma) 0.005% drops, instill 1 drop in both eyes every bedtime; April 1-3 at 8:00 p.m.	01820		

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01820	Continued From page 110 R3's record lacked signed prescriber orders for the above listed, and administered, medications. On April 4, 2023, at 10:21 a.m., RN-B stated she did not keep orders for the medications she set up for the residents. RN-B further stated she kept some after visit summaries for residents who had been seen by their provider, and they included a medication list, but were not signed. On April 4, 2023, at 2:55 p.m., RN-B stated R2 did not have any signed orders, and she entered the medications into his EMR earlier that day from the list that came with his medications. RN-B further stated R3 did not have any signed orders because he had no medication changes at his last appointment. RN-B further stated the pharmacy used by the residents would send updates to the medication list to the EMR and from that, she entered the information into the residents' MAR. The licensee's Medication and Treatment Orders policy, revised July1, 2010, indicated, "1) The RN is responsible for assuring that current, authorized prescriber orders for medications or treatments administered by the staff are kept on file in the clients' records and that changes in orders are addressed in the client's care plan and service plan and are communicated to the other staff. 2) An order for medication or treatment must be dated, signed by the prescriber and must be current and consistent with the client's nursing assessment." The policy further indicated, "The RN will assure that the prescriber renews a medication or treatment order at least every 12 months, or more frequently if determined necessary based on nursing assessment."	01820		

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01820	Continued From page 111 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		
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 and interview, the licensee failed to ensure medications were stored under proper temperature controls according to manufacturer instructions. This had the potential to affect three of three) residents (R1, R3, R6) with refrigerated medications. Further, the licensee failed to ensure all medications were securely locked in substantially constructed compartments and only authorized personnel had access. This had the potential to affect all eight residents in 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:	01880		

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01880	Continued From page 112 On April 3, 2023, at 11:09 a.m., the medication refrigerator, on the second level, in the dining area, was observed with unlicensed personnel (ULP)-D. The refrigerator was unlocked. Further the refrigerator lacked a thermometer and a log of temperature monitoring. ULP-D stated the refrigerator was always unlocked and she did not document the temperature of the refrigerator. -at 11:29 a.m., a thermometer was found inside an unlocked security box in the refrigerator. The thermometer indicated 45 degrees Fahrenheit (F). The medication refrigerator contained the following: R1 -2 Lantus Solostar pens (insulin glargine, a long-acting insulin, for diabetes), expiration April 6, 2023, and January 31, 2025; -2 insulin glargine pens, expiration March 2024. R3: -3 bottles latanoprost 0.005% (for glaucoma), labeled, "refrigerate until opened, Discard 42 days after open". R6: -1 Lantus Solostar pen, expiration November 30, 2024; -3 insulin aspart pens (a fast-acting insulin, for diabetes), expiration January 31, 2025. Unknown (ULP-D stated this belonged to R6): -one unlabeled box containing 2 unlabeled Novolog Flexpens (insulin aspart), with a sticker indicating "store refrigerated (2-8 deg [degrees] c [Celsius])". On April 3, 2023, at 11:32 a.m., licensed assisted living director (LALD)-A stated they did not	01880		

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01880	Continued From page 113 monitor the temperature of the medication refrigerator, Only men upstairs have refrigerated On April 5, 2023, at 10:11 a.m., registered nurse (RN)-B stated the medication refrigerator was not kept locked because R6 was independent with insulin administration. RN-B further stated R1 was not independent and his opened insulin pen was kept in the locked medication cabinet. RN-B stated she understood the need to keep the medication refrigerator locked and monitor the temperature regularly. Manufacturer storage instructions for Lantus Solostar (insulin glargine), revised December 2020 indicated,"Keep your SoloStar in cool storage (36°F-46°F [2°C-8°C]) until first use. Do not allow it to freeze. Do not put it next to the freezer compartment of your refrigerator or next to a freezer pack." Manufacturer storage instructions for Novolog Flexpen (insulin aspart), revised March 2021, indicated, "Do not freeze Novolog®. Do not use Novolog® if it has been frozen." The instructions further indicated, "Store unused Novolog® FlexPen® in the refrigerator at 36°F to 46°F (2°C to 8°C)." The licensee's Storage of Medications policy, revised July 1, 2010, indicated, "All medications will be placed in a locked medication cart or in a locked cabinet in the Assisted Living nursing office or designated location." The policy further indicated, "Any medications requiring refrigeration will be placed in a refrigerator in the Assisted Living nursing office." No further information was provided.	01880		

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01880	Continued From page 114 TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01930 SS=F	144G.72 Subd. 2 Policies and procedures (a) An assisted living facility that provides treatment and therapy management services must develop, implement, and maintain up-to-date written treatment or therapy management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse or appropriate licensed health professional consistent with current practice standards and guidelines. (b) The written policies and procedures must address requesting and receiving orders or prescriptions for treatments or therapies, providing the treatment or therapy, documenting treatment or therapy activities, educating and communicating with residents about treatments or therapies they are receiving, monitoring and evaluating the treatment or therapy, and communicating with the prescriber. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop, implement, and maintain an up-to-date written treatment or therapy management policies and procedures that were developed under the supervision and direction of a registered nurse (RN) consistent with current practice standards and guidelines. 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	01930		

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01930	Continued From page 115 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: On April 3, 2023, at 11:45 a.m., during the entrance conference the licensed assisted living director (LALD)-A stated, the licensee provided treatment and therapy management services to the licensee's residents. R1 had diagnoses including lumbago (low back pain), major depression and diabetes. R1's record included a Department of Human Services (DHS) "Customized Living Worksheet" (DHS form 6790G) dated February 21, 2023. The form indicated R1 needed "health related assistance" with delegated tasks including blood glucose (BG) checks daily. R1's record lacked a signed provider order for BG monitoring to include including the frequency, duration and other information needed to administer the treatment or therapy. On April 3, 2023, at 1:59 p.m., unlicensed personnel (ULP)-D, gathered supplies to check R1's BG level. R1 was out of the facility and unavailable, so the BG check could not be completed. ULP-D stated the BG check would be completed by the evening shift staff and she would document she did not complete because he was not available. On April 3, 2023, at 6:25 p.m., RN-B stated staff assist R1 with BG monitoring, but they had not	01930		

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01930	Continued From page 116 yet been documenting it in the medical record. -at 6:57 p.m., RN-B stated R1 did not have a treatment management plan and she had not completed training with ULP-D on BG monitoring. The policies reviewed in the licensee's policy binder were last revised July 1, 2010 (11 years before 144G Assisted Living statutes). The licensee lacked the following required policies: - educating and communicating with residents about treatments or therapies they are receiving; - monitoring and evaluating the treatment or therapy; - documenting treatment or therapy activities; and - communicating with the prescriber. The licensee lacked up to date treatment and therapy management policies concurrent with 144G Assisted Living statutes. On April 3, 2023, at 1:30 p.m., LALD-A stated the policies and procedures that were being used by the licensee were from 2010, and he would need to get new ones. LALD-A further stated the policies were purchased from the previous owner in July, 2022, when LALD-A purchased the business. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01930		
01940 SS=G	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	01940		

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01940	Continued From page 117 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. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for one of two residents (R1). This resulted in an immediate correction order issued on April 3, 2023, at approximately 7:30 p.m. This practice resulted in a level three violation (a	01940		

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01940	Continued From page 118 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: R1 R1 had diagnoses including lumbago (low back pain), major depression and diabetes, and received services including assistance with blood glucose (BG) management. R1's record included an after visit summary, dated March 9, 2023, indicating R1 was admitted to the facility after being hospitalized for hyperglycemia (high blood sugar) and dehydration. On April 3, 2023, at 11:02 a.m., unlicensed personnel (ULP)-D stated R1 had regular BG checks which he was able to do on his own, but staff verified it was done and documented the BG level. ULP-D further stated staff does sometimes assist R1 to check his BG level if he needs help. R1's record lacked a treatment or therapy management plan to include 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	01940		

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01940	Continued From page 119 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. -In addition, R1's record lacked a provider order for BG monitoring. ULP-D was hired November 15, 2022, and provided direct cares for residents of the facility. ULP-D's employee record lacked documentation of training on assisting residents with treatments or therapies including BG monitoring. On April 3, 2023, at 1:59 p.m., unlicensed personnel ULP-D, was observed to attempt to check R1's BG level. R1 was out of the facility and unavailable, so the BG check could not be completed. ULP-D stated the BG check would be completed by the evening shift staff and she would document it was not completed because he was not available. On April 3, 2023, at 6:25 p.m., registered nurse (RN)-B stated staff assist R1 with BG monitoring, but they had not yet been documenting it in the medical record. -at 6:57 p.m., RN-B stated R1 did not have a treatment management plan and she had not completed training with ULP-D on BG monitoring. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate An immediate correction order was identified on	01940		

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01940	Continued From page 120 April 3, 2023, at approximately 7:30 p.m., and issued for licensing order 1940 related to treatment and therapy management. On April 5, 2023, at approximately 1:00 p.m., the immediacy of the correction order for 1940 was removed, the scope and level was unchanged.	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: Based on observation, interview and record review, the licensee failed to document treatment administration for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include:	01960		

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01960	Continued From page 121 R1 R1 had diagnoses including lumbago (low back pain), major depression and diabetes. R1's record included a Department of Human Services (DHS) "Customized Living Worksheet" (DHS form 6790G) dated February 21, 2023. The form indicated R1 needed "health related assistance" with delegated tasks including blood glucose checks daily. On April 3, at 12:08 p.m., licensed assisted living director (LALD)-A stated they used the residents' "6790 form" to determine the services needed. On April 3, 2023, at 11:02 a.m., unlicensed personnel (ULP)-D stated R1 had regular BG checks which he was able to do on his own, but staff verified it was done and documented the BG level. ULP-D further stated staff did sometimes assist R1 to check his BG level if he needed help. On April 3, 2023, at 1:59 p.m., unlicensed personnel ULP-D, gathered supplies to check R1's BG level. R1 was out of the facility and unavailable, so the BG check could not be completed. ULP-D stated the BG check would be completed by the evening shift staff and she would document she did not complete because R1 was not available. R1's record lacked documentation of BG levels or ULP assistance with BG monitoring. On April 3, 2023, at 6:25 p.m., registered nurse (RN)-B stated staff assist R1 with BG monitoring, but they had not been documenting the assistance or R1's BG level in the medical record. -at 6:57 p.m., RN-B stated R1 did not have a	01960		

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01960	Continued From page 122 treatment management plan and she did not provide training to ULP-D on the BG monitoring process. No further information was provided. TIME PERIOD OF CORRECTION: Seven (7) days	01960		
01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to obtain prescriber orders for all treatments and therapies, including the frequency, duration and other information needed to administer the treatment or therapy for one of three residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33425	A. BUILDING: _____ B. WING _____	04/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RESTFUL HOME LLC	1000 REANEY AVENUE SAINT PAUL, MN 55106

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01970	Continued From page 123 The findings include: R1 R1 had diagnoses including lumbago (low back pain), major depression and diabetes. R1's record included a Department of Human Services (DHS) "Customized Living Worksheet" (DHS form 6790G) dated February 21, 2023. The form indicated R1 needed "health related assistance" with delegated tasks including blood glucose (BG) checks daily. On April 3, at 12:08 p.m., licensed assisted living director (LALD)-A stated they used the residents' "6790 form" to determine the services needed. R1's record lacked a signed provider order for BG monitoring to include including the frequency, duration and other information needed to administer the treatment or therapy. On April 3, 2023, at 1:59 p.m., unlicensed personnel ULP-D, gathered supplies to check R1's BG level. R1 was out of the facility and unavailable, so the BG check could not be completed. ULP-D stated the BG check would be completed by the evening shift staff and she would document she did not complete because he was not available. On April 5, 2023, at 10:11 a.m., RN-B stated, R1 was not independent with BG monitoring, R1's glucometer was locked in the medication cabinet, and staff brought the glucometer to R1 when it was time to test BG. RN-A stated, there was not a signed order for R1's BG monitoring. The licensee's Medication and Treatment Orders	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33425	A. BUILDING: _____ B. WING _____	04/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RESTFUL HOME LLC	1000 REANEY AVENUE SAINT PAUL, MN 55106

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01970	Continued From page 124 policy, revised July 1, 2010, indicated, "A current, written prescriber's order must be obtained for any treatment provided to a client." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970		
02240 SS=E	144G.90 Subdivision 1 Assisted living bill of rights; notification (a) An assisted living facility must provide the resident a written notice of the rights under section 144G.91 before the initiation of services to that resident. The facility shall make all reasonable efforts to provide notice of the rights to the resident in a language the resident can understand. (b) In addition to the text of the assisted living bill of rights in section 144G.91, the notice shall also contain the following statement describing how to file a complaint or report suspected abuse: "If you want to report suspected abuse, neglect, or financial exploitation, you may contact the Minnesota Adult Abuse Reporting Center (MAARC). If you have a complaint about the facility or person providing your services, you may contact the Office of Health Facility Complaints, Minnesota Department of Health. If you would like to request advocacy services, you may contact the Office of Ombudsman for Long-Term Care or the Office of Ombudsman for Mental Health and Developmental Disabilities." (c) The statement must include contact information for the Minnesota Adult Abuse Reporting Center and the telephone number, website address, email address, mailing address, and street address of the Office of Health Facility	02240		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33425	A. BUILDING: _____ B. WING _____	04/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RESTFUL HOME LLC	1000 REANEY AVENUE SAINT PAUL, MN 55106

(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
02240	Continued From page 125 Complaints at the Minnesota Department of Health, the Office of Ombudsman for Long-Term Care, and the Office of Ombudsman for Mental Health and Developmental Disabilities. The statement must include the facility's name, address, email, telephone number, and name or title of the person at the facility to whom problems or complaints may be directed. It must also include a statement that the facility will not retaliate because of a complaint. (d) A facility must obtain written acknowledgment from the resident of the resident's receipt of the assisted living bill of rights or shall document why an acknowledgment cannot be obtained. Acknowledgment of receipt shall be retained in the resident's record. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the current "Minnesota Bill of Rights for Assisted Living Residents" was provided to the resident and a written acknowledgement received for two of two residents (R1, 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) 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 was admitted on March 9, 2023, and received services including assistance with housekeeping,	02240		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33425	A. BUILDING: _____ B. WING _____	04/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RESTFUL HOME LLC	1000 REANEY AVENUE SAINT PAUL, MN 55106

(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
02240	Continued From page 126 and medication administration. R3 was admitted June 9, 2022, and received services including assistance with activities of daily living (ADLs), toileting, housekeeping, meals, laundry, and medication administration. R1 and R3's record lacked documentation of receipt of the current Assisted Living Bill of Rights. On April 3, 2023, at 12:17 p.m., during the entrance conference, licensed assisted living director (LALD)-A stated, there was a rent agreement, and indicated there were no assisted living contracts. In addition, LALD-A stated, he had no evidence to indicate that the residents received the current assisted living bill of rights. On April 5, 2023, at 1:19 p.m., LALD-A stated, he had no documents signed by any of the residents at admission. The licensee's Bill of Rights policy, dated July 1, 2010, included, "1. Residents will be informed of residents' bill of rights in writing. This may be accomplished by giving them a copy of the Home Care Bill of Rights. 2. The President, Housing Manager and RN are responsible for ensuring that resident rights are respected and maintained. It will serve as a forum to hear resident grievances and will work with the resident, responsible person or family, and management toward resolution. 3. All staff will be an advocate for resident rights. 4. All staff will receive training on resident bill of rights prior to assignment. 5. The list of the Home Care Bill of Rights will be available for residents to review at any time." No further information was provided.	02240		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33425	A. BUILDING: _____ B. WING _____	04/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RESTFUL HOME LLC	1000 REANEY AVENUE SAINT PAUL, MN 55106

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02240	Continued From page 127 TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02240		

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

Type: Full
Date: *04/03/23*
Time: 14:45:23
Report: 1021231095

Food and Beverage Establishment Inspection Report

Location:
Restful Home LLC
1000 Reaney Avenue
St Paul, MN55106
Ramsey County, 62

Establishment Info:
ID #: 0038988
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 6513249591
ID #:

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

The following orders previously issued on 04/03/23 have NOT been corrected.

2-200 Employee Health

2-201.11C ***** Priority 1 *****

MN Rule 4626.0040C The person in charge must record all reports of diarrhea or vomiting made by food employees and report those illnesses to the regulatory authority at the specific request of the regulatory authority.

NO EMPLOYEE ILLNESS LOG ON-SITE DURING INSPECTION. DISCUSSED EMPLOYEE ILLNESS POLICY AND RECORDING WITH ADMINISTRATOR. AN MDH EMPLOYEE ILLNESS LOG SENT WITH REPORT.

Issued on: 04/03/23 *Comply By: 04/04/23*

3-300B Protection from Contamination: cross-contamination, eggs

3-302.11A(1) ***** Priority 1 *****

MN Rule 4626.0235A(1) Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.

RAW SHELL EGGS AND RAW PORK FOUND STORED ABOVE READY TO EAT FOODS LIKE GRAPES, JUICE AND SAUCES IN THE WHIRLPOOL KITCHEN REFRIGERATOR. STAFF MOVED RAW SHELL EGGS AND RAW PORK TO BOTTOM SHELF TO PREVENT CROSS CONTAMINATION. CORRECTED ON-SITE.

Issued on: 04/03/23 *Comply By: 04/03/23*

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.

STAFF ARE ONLY WASHING AND RINSING THE DISHES AND UTENSILS IN THE TWO COMPARTMENT SINK. DISCUSSED WITH ADMINISTARTOR AND STAFF THAT ALL DISHES AND UTENSILS NEED TO BE WASHED, RINSED AND SANITIZED. COMPLY WITH RULE

ABOVE. SEE COMMENTS.

Issued on: 04/03/23 *Comply By: 04/03/23*

2-500 Responding to contamination events

2-501.11 ***** Priority 2 *****

MN Rule 4626.0123 Provide employees with procedures to follow for cleanup of vomit or fecal matter in the establishment. The procedures must minimize the spread of contamination to food and surfaces within the facility, and minimize the exposure of employees and consumers to contamination.

NO PROCEDURES FOR EMPLOYEES TO FOLLOW IN CASE OF A FECAL/VOMITING ACCIDENT. MAKE SURE TO TRAIN EMPLOYEES ON HOW TO PROPERLY CLEAN-UP ACCIDENTS. FACT SHEET SENT WITH REPORT.

Issued on: 04/03/23 *Comply By: 04/11/23*

4-300 Equipment Numbers and Capacities

4-302.12B ***** Priority 2 *****

MN Rule 4626.0705B Provide a readily accessible food temperature measuring device with a small diameter probe to measure the temperature in thin foods such as meat patties and fish fillets.

NO FOOD THERMOMETER ON-SITE. PROVIDE A THIN PROBE DIGITAL THERMOMETER. DISCUSSED WITH STAFF THE METHODS TO CLEAN AND SANITIZE THE FOOD THERMOMETER PROBE.

Issued on: 04/03/23 *Comply By: 04/07/23*

4-300 Equipment Numbers and Capacities

4-302.14 ***** Priority 2 *****

MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.

NO TEST KIT ON-SITE TO MEASURE THE CONCENTRATION OF BLEACH. PROVIDE.

Issued on: 04/03/23 *Comply By: 04/10/23*

5-200C Plumbing: Maintenance, fixture location

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

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

KITCHEN HAS A TWO COMPARTMENT SINK AND THE HANDWASHING SINK IS NOT CLEARLY DESIGNATED. BOTH COMPARTMENTS OF THE SINK HAD DIRTY DISHES/UTENSILS IN THEM. THE LEFT SIDE COMPARTMENT HAS A PAPER TOWEL DISPENSER, SOAP AND HANDWASHING SIGNAGE. SEE COMMENTS.

Issued on: 04/03/23 *Comply By: 04/03/23*

2-100 Supervision

2-102.12AMN

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

NO CERTIFIED FOOD PROTECTION MANAGER (CFPM) WAS EMPLOYED AT THIS ESTABLISHMENT. YER XIONG HAS A FOOD SAFETY CERTIFICATE POSTED ON-SITE BUT NOT A CFPM CERTIFICATE. INFORMATION ON HOW TO OBTAIN CFPM CERTIFICATE SENT WITH REPORT.

Issued on: 04/03/23 *Comply By: 05/03/23*

4-200 Equipment Design and Construction

4-204.112A

MN Rule 4626.0620A Provide a temperature measuring device located in the warmest part of mechanically refrigerated units and coolest part of hot food storage units that are capable of measuring air temperature or a simulated product temperature.

NO THERMOMETER FOUND IN THE WHIRLPOOL KITCHEN REFRIGERATOR. PROVIDE A THERMOMETER IN THE WARMEST PART OF THE REFRIGERATOR AS DESCRIBED IN RULE ABOVE.

Issued on: 04/03/23 *Comply By: 04/10/23*

4-300 Equipment Numbers and Capacities

4-303.11B

MN Rule 4626.0721B Provide chemical sanitizers to sanitize equipment and utensils during all hours of operation.

NO CHEMICAL SANITIZER ON-SITE DURING INSPECTION. PER CONVERSATION WITH ADMINISTRATOR, THEY WILL BUY BLEACH TODAY. DISCUSSED THE APPROVED CHEMICAL SANITIZERS THAT ARE APPROVED WITH FOOD CONTACT SURFACES.

Issued on: 04/03/23 *Comply By: 04/03/23*

4-500 Equipment Maintenance and Operation

4-501.11AB

MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.

THE DISH MACHINE IS CURRENTLY NOT WORKING. ESTABLISHMENT IS GOING TO REPLACE THE DISH MACHINE. DISCUSSED WITH ADMINISTRATOR THAT THE NEW DISHWASHER NEEDS TO MEET THE RESIDENTIAL DISHWASHER STANDARD NSF/ANSI 184. FACT SHEET SENT WITH REPORT.

Issued on: 04/03/23 *Comply By: 04/24/23*

4-600 Cleaning Equipment and Utensils

4-601.11C

MN Rule 4626.0840C Clean non-food contact surfaces of equipment and maintain free of accumulations of dust, dirt, food residue, and other debris.

GREASE ACCUMULATION AROUND AND UNDER THE VENTILATION HOOD AND ON THE FILTER COVER. CLEAN AND MAINTAIN CLEAN.

Issued on: 04/03/23 *Comply By: 04/10/23*

6-200 Physical Facility Design and Construction

6-202.16A

MN Rule 4626.1400A Eliminate any openings on perimeter walls and roof of the establishment to protect the establishment from the weather and the entry of insects, rodents, or other animals.

THE AC/HEATER VENT GRILLE/COVER IS MISSING UNDER THE KITCHEN TWO COMPARTMENT SINK. PLACE THE GRILLE/COVER TO PREVENT THE ENTRY OF PESTS.

Type: Full
Date: *04/03/23*
Time: 14:45:23
Report: 1021231095
Restful Home LLC

Food and Beverage Establishment Inspection Report

Issued on: 04/03/23 *Comply By: 04/17/23*

No NEW orders were issued during this inspection.

Food and Equipment Temperatures

Process/Item: Ambient Temperature
Temperature: 39 Degrees Fahrenheit - Location: WHIRLPOOL REFRIGERATOR
Violation Issued: No

Process/Item: Cold Holding
Temperature: 40 Degrees Fahrenheit - Location: RAW PORK - WHIRLPOOL REFRIGERATOR
Violation Issued: No

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	3	4	6

ALL FINDINGS ON THIS REPORT WERE DISCUSSED WITH ADMINISTRATOR, YER XIONG AND HEALTH REGULATION DIVISION NURSE EVALUATORS, DEDE HINNENDAEL AND RENEE ANDERSON.

THIS FACILITY HAS A RESIDENTIAL HOME KITCHEN. THEY CURRENTLY HAVE 8 CLIENTS AND CAN HAVE UP TO 10 CLIENTS.

PER CONVERSATION WITH YER, FOOD IS MADE FOR SAME DAY SERVICE. NO LEFTOVERS ARE KEPT.

THE KITCHEN HAS RESIDENTIAL EQUIPMENT, LAMINATE FLOORING, WOOD CABINETS, TEXTURED CEILING, AND LAMINATE COUNTERS. PHYSICAL FACILITY ITEMS WILL BE MONITORED AT FUTURE INSPECTIONS.

CONTINUATION OF MN Rule 4626.0900
PER CONVERSATION WITH STAFF, THEY WILL WASH AND RINSE DISHES/UTENSILS IN ONE COMPARTMENT OF THE KITCHEN SINK, AND THEY WILL SANITIZE IN A CONTAINER WITH WATER AND BLEACH UNTIL THEY REPLACE THE DISH MACHINE.

CONTINUATION OF MN Rule 4626.1110AB
STAFF DECIDED DURING INSPECTION THAT THE LEFT SIDE COMPARTMENT OF THE TWO COMPARTMENT KITCHEN SINK WILL BE USED ONLY FOR THE WASHING OF THE HANDS.

Type: Full
Date: *04/03/23*
Time: 14:45:23
Report: 1021231095
Restful Home LLC

Food and Beverage Establishment Inspection Report

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Minnesota Department of Health inspection report number 1021231095 of 04/03/23.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /

Inspection report reviewed with person in charge and emailed.

Signed:_____
YER XIONG
ADMINISTRATOR

Signed:_____
Melissa Ramos
Environmental Health Specialist
Metro District Office
651-201-4495
Melissa.Ramos@state.mn.us