Electronically Delivered

November 16, 2023

Licensee
Family Tree Care Homes
2029 Palmer Drive
New Brighton, MN 55112

RE: Project Number(s) SL33728015

Dear Licensee:

On November 6, 2023, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the May 31, 2023, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

Tim Hanna, Interim Supervisor
State Engineering Services Section
Email: tim.hanna@state.mn.us
Telephone: 507-208-8982 Fax: 1-866-890-9290

PMB

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

August 22, 2023

Licensee
Family Tree Care Homes
2029 Palmer Drive
New Brighton, MN 55112

RE: Project Number(s) SL33728015

Dear Licensee:

On August 4, 2023, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on May 31, 2023. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the May 31, 2023 survey.

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

0820-Fire Protection And Physical Environment-144g.45 Subd. 2 (g) - $500.00

The details of the violations noted at the time of this follow-up survey completed on August 4, 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 approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

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

IMPOSITION OF FINES:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

A state correction order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

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

Please address your cover letter for reconsideration requests to:

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

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the MDH within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. Requests for hearing may be emailed to: **Health.HRD.Appeals@state.mn.us**.

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both.

We urge you to review these orders carefully. If you have questions, please contact Jonathan Hill at 651-201-3993.

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,

Jonathan Hill, Supervisor
State Evaluation Team
Email: jonathan.hill@state.mn.us
Telephone: 651-201-3993 Fax: 651-281-9796

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33728	A. BUILDING: _____ B. WING _____	R 08/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAMILY TREE CARE HOMES	2029 PALMER DRIVE NEW BRIGHTON, MN 55112

(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 SL33728015 On July 31, 2023, through August 4, 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 June 1, 2023. At the time of the survey, there were four residents: four receiving services under the Assisted Living with Dementia Care license. As a result of the revisit, the following orders were reissued.	{0 000}	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
{0 820} SS=F	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including	{0 820}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33728	A. BUILDING: _____ B. WING _____	R 08/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAMILY TREE CARE HOMES	2029 PALMER DRIVE NEW BRIGHTON, MN 55112

(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
{0 820}	Continued From page 1 assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to 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 ability to affect a limited number of staff and residents. This practice resulted in a level two distinct hazard violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On the follow-up survey for the facility with the Licensed Assisted Living Director (LALD)-D between approximately 11:00 AM and 12:00 PM on July 31, 2023, it was observed that the door	{0 820}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33728	A. BUILDING: _____ B. WING _____	R 08/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAMILY TREE CARE HOMES	2029 PALMER DRIVE NEW BRIGHTON, MN 55112

(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
{0 820}	Continued From page 2 locking arrangements for the front and rear door exits of the facility remained improperly in place. The observed exit doors require a code to exit that does not release upon activation of the fire alarm, fire sprinkler, or loss of power. Any occupants would not be allowed to evacuate the facility in the event of an emergency under these conditions. LALD-D stated that they had provided a key and the unlocking code to the exits, but these items did not satisfy the requirements to safely evacuate the facility in the event of an emergency. This deficient condition was visually verified by LALD-D accompanying on the tour.	{0 820}		

Electronically Delivered

July 6, 2023

Licensee
Family Tree Care Homes
2029 Palmer Drive
New Brighton, MN 55112

RE: Project Number(s) SL33728015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on May 31, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

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

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

circumstance.

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

St - 0 - 0495 - 144g.41 Subd. 1 (14) - Minimum Requirements - $3,000.00
St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - $3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $6,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

A state correction order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

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

Please address your cover letter for reconsideration requests to:

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

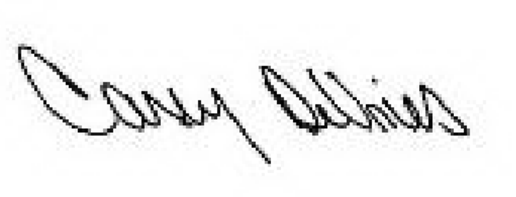
REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the MDH within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. Requests for hearing may be emailed to: **Health.HRD.Appeals@state.mn.us**.

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both.

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

If you have any questions, please contact me.

Sincerely,



Casey DeVries, Supervisor
State Evaluation Team
Email: casey.devries@state.mn.us
Telephone: 651-201-5917 Fax: 651-281-9796

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33728	A. BUILDING: _____ B. WING _____	05/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAMILY TREE CARE HOMES	2029 PALMER DRIVE NEW BRIGHTON, MN 55112

(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: SL33728015-0 On May 30, 2023, through June 1, 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 four active residents receiving services under the Assisted Living with Dementia Care license. An immediate correction order was identified on May 30, 2023, issued for SL33728015-0, tag identification 0495 at 3:32 p.m. The immediacy for the correction order identified on May 30, 2023, issued for SL33728015-0, tag identification 0495, is removed as of May 31, 2023. The scope and level remain unchanged. An immediate correction order was identified on May 31, 2023, issued for SL33728015-0, tag identification 2310 at 2:31 p.m.	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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Continued From page 1 The immediacy for the correction order identified on May 31, 2023, issued for SL33728015-0, tag identification 2310, is removed as of June 1, 2023. The scope and level remain unchanged.	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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33728	A. BUILDING: _____ B. WING _____	05/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAMILY TREE CARE HOMES	2029 PALMER DRIVE NEW BRIGHTON, MN 55112

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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 observation, 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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33728	A. BUILDING: _____ B. WING _____	05/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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: During the entrance conference on May 30, 2023, at 10:08 a.m., licensed assisted living director (LALD)-C and registered nurse (RN)-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. - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G.	0 250		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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0 250	Continued From page 4 - 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 are considered private until MDH issues a license. - I declare that, as the owner or authorized agent,	0 250		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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FAMILY TREE CARE HOMES	2029 PALMER DRIVE NEW BRIGHTON, MN 55112

(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
0 250	Continued From page 5 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. Page Six was electronically signed by Authorized Agent/LALD-C on May 26, 2022. The licensee had an Assisted Living with Dementia Care license issued on April 1, 2023, with an expiration date of March 31, 2024. The licensee failed to ensure the following policies and procedures were developed and/or implemented: - staff orientation and training; - infection control practices; - nursing assessments; - contract content; - appropriate cares and services; - medication and treatment management and	0 250		

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	33728	A. BUILDING: _____ B. WING _____	05/31/2023

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0 250	Continued From page 6 orders; - service plans; - dementia training; and - staffing and RN availability. On June 1, 2023, at 2:30 p.m., LALD-C and RN-A confirmed the licensee provided Assisted Living with Dementia Care services but failed to develop and implement corresponding policies and procedures, as required. As a result of this survey, the following orders were issued 0250, 0470, 0480, 0495, 0510, 0550, 0640, 0680, 0700, 0810, 0820, 0950, 0970, 1470, 1620, 1640, 1650, 1700, 1760, 1820, 1890, 1970, 2110, 2310, 3090 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		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies	0 470		

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0 470	Continued From page 7 and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a staffing plan to determine staffing levels to meet the needs of all residents and failed to ensure the required staffing plan was posted for residents, staff, and visitors to review as required. Further the licensee failed to ensure a second staff member was located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time for available for two-person transfer assists. 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	0 470		

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0 470	Continued From page 8 problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's ownership, registered nurse (RN)-A and licensed assisted living director (LALD)-C, lived in a private home immediately next door to licensee/facility. They also owned a second separately licensed facility which was approximately an 11-minute drive away per google maps. STAFFING PLAN The licensee's Staffing, Direct-Care Staffing Plan & Daily Schedule dated January 6, 2023, lacked licensee's tailored information used to determine staffing including: -census; -resident needs; -an evaluation to be conducted at least twice a year of appropriateness of staffing levels in the facility; there was only record of one evaluation; -ensure sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and -ensures the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety and disaster situations affecting staff or residents in the facility. STAFF AVAILABILITY The licensee's Uniform Disclosure of Assisted Living Services and Amenities (UDALSA) dated March 1, 2022, indicated they provided	0 470		

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0 470	Continued From page 9 mechanical lifts with the assist of two staff. R1 R1's Care Plan, unsigned or dated, indicated R1 received services for activities of daily living (ADL's), two-person Hoyer lift transfers, toileting, medication management, behavior management, and meal assistance. R4 R4's Care Plan, unsigned or dated, indicated R4 received services for ADL, one-person Hoyer lift transfer, toileting, medication management, and meal assistance. On May 30, 2023, at 10:08 a.m., during the entrance conference, LALD-C and RN-A stated they owned a second licensed assisted living facility (ALF). In addition, RN-A stated they were employed as a floor nurse at Mercy Hospital on an orthopedic trauma unit, scheduled part-time working three 12-hour shifts every two weeks at a 0.45 (45% of a two-week 80-hour schedule), and both LALD-C and RN-A split their time between their two facilities. On May 30, 2023, at 10:08 a.m., during the entrance conference LALD-C stated they had two unlicensed personnel (ULP) shifts each day scheduled as follows: -day shift scheduled from 8:00 a.m. to 6:00 p.m.; -overnight shift scheduled from 6:00 p.m. to 6:00 a.m.; and -RN-A and LALD-C cover the hours from 6:00 a.m. and 8:00 a.m., with one of each at their two facilities, there was no schedule to support this. On May 30, 2023, at 11:47 a.m., the surveyor observed ULP-B and LALD-C perform a two-person Hoyer lift transfer for R4.	0 470		

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0 470	Continued From page 10 On May 31, 2023, at 9:58 a.m., the survyor observed ULP-B perform a one-person standby assist transfer for R1. On May 31, 2023, at 10:41 a.m., the surveyor observed ULP-B and LALD-C perform a two-person transfer with a Hoyer lift for R4. On May 30, 2023, at 1:57 p.m. LALD-C stated they didn't have an actual staffing plan only a policy that was used for their two licensed locations. LALD-C stated RN-A and LALD-C were not always at the facilities but could go to the facility whenever assistance was needed. On May 30, 2023, at 2:17 p.m., ULP-B stated R1 doesn't use the bathroom anymore and instead, goes in his brief. If R1 needed to be changed he could be transferred into bed with an assist of one staff versus two, or if needed, staff could contact LALD-C or RN-A to come and assist. On May 31, 2023, at 10:20 a.m., the surveyor inquired if it was realistic to rely on RN-A or LALD-C to be the second available staff from the home next door at all times. RN-A stated someone was always available for two-person transfers. Surveyor asked if they ever take vacations to which RN-A stated, "No." Surveyor asked what they would do in the event the LALD-C or RN-A were sick, RN-A stated they could wear a mask. On May 31, 2023, at 2:18 p.m., the surveyor contacted LALD-D and RN-A via phone to inform them of a separate citation. At the time of the call, both LALD-D and RN-A were at their second licensed location, therefore, neither were available for two-person transfer assistance at the	0 470		

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0 470	Continued From page 11 licensee. On June 1, 2023, at 8:35 a.m., LALD-C stated they did not have a schedule or documentation of when LALD-C and RN-A worked. LALD-C stated in the mornings LALD-C and RN-A each worked at one of their two facilities daily between the overnight and day shift from 6:00 a.m. and 8:00 a.m. During those two hours they were the only two staff members working between the two separately licensed locations. LALD-C stated their mother was an employee of the facility and if both of them had to be away she would cover for them staying at their house and had done so in the past. LALD-C and RN-A stated R1 went to bed around 5:00 or 6:00 p.m., but had the option to stay up later. LALD-C stated their day and overnight shifts overlapped. Surveyor stated overlap was not indicated in the scheduling they reported at the entrance conference with the day shift ending and the overnight shift beginning at 6:00 p.m. LALD-C stated the day shift ULP would have to stay late until R1 was ready for bed, or the LALD-C or RN-A could assist with the transfer. On June 1, 2023, at 2:30 p.m., LALD-C stated on June 2, 2023, they had a field trip with one of their children and both LALD-C and RN-A would be attending, his mother would be covering the facilities while they were gone. The licensee's Staffing, Direct-Care Staffing Plan and Daily Schedule policy dated January 6, 2023, indicated: "a. From the hours of 10:00pm to 6:00am, direct-care staff will respond to a resident request for assistance with health or safety needs within a reasonable amount of time. b. A minimum of two direct-care staff will be	0 470		

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0 470	Continued From page 12 scheduled and available to assist at all times whenever a resident requires the assistance of two. c. One or more persons will be available 24-hours per day, seven days per week who are responsible for responding to the requests of residents for assistance for health and safety needs. Persons will be: i. Awake ii. Located in: 1. The same building -OR- 2. An attached building -OR- 3. On a contiguous campus within the facility in order to respond within a reasonable amount of time iii. Capable of communicating with residents iv. Capable of summoning appropriate assistance v. Capable of following directions" No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 470		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to adhere to the Minnesota Food Code, Minnesota Rules, chapter	0 480		

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0 480	Continued From page 13 4626. This had the potential to affect all residents 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: Please refer to the additional documentation included in the "Food and Beverage Establishment Inspection Reports," dated May 30, 2023. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
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 and residents had access to a registered nurse (RN) on-call for current and foreseeable needs 24 hours a day, seven days per week due to part time employment at a hospital. This had the potential to affect all residents and staff of the licensee. This practice resulted in a level three violation (a	0 495	The immediacy for the correction order identified on May 30, 2023, issued for SL33728015-0, tag identification 0495, was removed on May 31, 2023. The scope and level remained unchanged.	

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0 495	Continued From page 14 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: On May 30, 2023, at 10:08 a.m., during the entrance conference, licensed assisted living director/owner (LALD)-C and registered nurse/owner (RN)-A stated RN-A was the only nurse working at the licensee. They stated they also owned a second licensed assisted living facility (ALF), and stated RN-A was also the nurse for that facility. In addition, RN-A stated they were employed as a floor nurse at Mercy Hospital on an orthopedic trauma unit, scheduled part-time working three 12-hour shift every two weeks at a 0.45 (45% of a two-week 80-hour schedule). Both stated the licensee did not employ any other nurses. LALD-C stated they did have a staffing agency they could use but had never used it. RN-A stated they could take calls while working at the hospital and could leave whenever they needed to address issues at the licensee. RN-A stated, "I'm a union nurse, leaving the hospital wouldn't be a problem, the residents are like my family." LALD-C stated they would also be available but was not a nurse. RN-A stated they would call 911 if it were something serious and they could not get there. RN-A's employee record indicated they had been employed since July 2018 when they took ownership of the facility (licensee was unable to provide surveyor with date of hire). RN-A's	0 495		

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0 495	Continued From page 15 responsibilities included assessments of residents, developing service plans, staff training, and resident cares. RN-A split time between three nursing roles at their two licensed ALFs and hospital shifts. On May 30, 2023, at 12:35 p.m., unlicensed personnel (ULP)-B confirmed RN-A had outside employment at a hospital and thus far, ULP had not encountered any situations where they had been unable to reach RN-A. On May 30, 2023, at 1:57 p.m., LALD-C stated they did not have a staffing plan only a staffing policy. They did not have a staffing plan to include current needs of their current resident and how many nurses would be required to meet resident needs. On May 30, 2023, at 2:22 p.m., RN-A stated they had been employed at both the hospital and as the licensee's nurse since they took ownership in July 2018. On May 30, 2023, at 2:55 p.m., RN-A stated her work schedule at the hospital did require working weekends and holidays. LALD-C and RN-A stated 911 could be called if RN-A was not available, surveyor explained in both instances a resident should not have to extend their hospital stay due their nurse being unavailable nor should 911 be utilized as a solution for nurse's unavailability. The licensee's Staffing, Direct-Care Staffing Plan & Daily Schedule policy dated August 1, 2021, last reviewed on January 6, 2023, indicated, "A Registered Nurse will be available to staff working at all times. Availability may be in person, via phone, or via other electronic communication method."	0 495		

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0 495	Continued From page 16 TIME PERIOD FOR CORRECTION: IMMEDIATE *Amendment to the following statement was made upon further discussion/clarification with LALD-C and RN-A on May 31, 2023, 7:41 a.m., after the issuance of the immediate correction order. On May 30, 2023, at 2:55 p.m., RN-A stated her work schedule at the hospital did require working weekends and holidays. RN-A stated if a readmission were to come at any of those times when they were at their hospital job they could tell the discharging hospital a nurse wasn't available and to delay the readmission until the nurse was available. LALD-D and RN-A stated 911 could be called if RN-A was not available, surveyor explained in both instances a resident should not have to extend their hospital stay due their nurse being unavailable nor should 911 be utilized as a solution for nurse's unavailability.	0 495		
0 510 SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced	0 510		

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0 510	Continued From page 17 by: Based on observation, interview, and record review, the licensee failed to establish and maintain an infection control program that complies with accepted health care, medical and nursing standards for infection control. The deficient practice had the potential to affect residents, employees, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: Unlicensed personnel (ULP)-B was hired September 2022 (exact date not provided), and was observed providing direct cares to residents on May 30-31, 2023, and June 1, 2023. Their employee record included completion of infection control training at the time of hire. On May 31, 2023, at 9:58 a.m., ULP-B washed their hands and donned (put on) gloves and assisted R1 with activities of daily living (ADL's). ULP-B changed R1's soiled brief and provided perineal (peri) cares (cleaning private areas) with wet wipes both front and back sides. ULP-B did not doff (remove) their soiled gloves after providing peri cares. ULP-B picked up R1's hospital bed remote control to raise the bed, applied socks to both feet, applied a clean brief, assisted with dressing including socks, pants, shoes, removed R1's night shirt and put on a new shirt, gave R1 his walker, and applied baby	0 510		

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0 510	Continued From page 18 powder to R1's buttocks. ULP-B then doffed their soiled gloves but did not wash or sanitize their hands. ULP-B took R1 to the bathroom, wet a towel, then used the towel to wipe mucus build up from R1's eyes. ULP-B then stepped out of the room, grabbed R2's walker and brought it to them, then returned to R1 and wiped their mouth with the same wet towel. ULP-B brought R1 to the kitchen where ULP-B then washed their hands with soap and water. On June 1, 2023, at 8:18 a.m., ULP-B acknowledged their lack of hand hygiene and stated R1 was their highest needs resident and was hard to stop in the middle of cares to wash or sanitize their hands. ULP-B stated having hand sanitizer available would be a good idea to always have available in his room. ULP-B stated they were trained in infection control when hired and were likely trained in the proper donning and doffing of gloves. On June 1, 2023, at 8:35 a.m., registered nurse (RN)-A stated the donning and doffing procedure the surveyor observed with ULP-B was incorrect. RN-A stated they had done the infection control and glove procedure training with ULP-B. RN-A stated staff should be washing or sanitizing their hands before and after cares and with any glove changes. They stated the correct practice was for gloves to be doffed after peri cares followed by immediate hand hygiene. The licensee's Hand Hygiene policy, undated, indicated: "1. When Hands Should be Washed. Hand washing shall be performed between resident cares and whenever direct physical contact with a resident takes place. Use of gloves does not replace hand washing. Hands should be washed	0 510		

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	33728	A. BUILDING: _____ B. WING _____	05/31/2023

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0 510	Continued From page 19 or decontaminated: a. Before and after direct contact with a resident b. If moving from a contaminated-body site to a clean-body site during resident care c. After contact with environmental surfaces or equipment in the immediate vicinity of the resident d. After removing gloves or gowns e. Before eating and after using a restroom" No further information provided. TIME PERIOD FOR CORRECTION: Two (2) 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 Health. This MN Requirement is not met as evidenced by:	0 550		

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0 550	Continued From page 20 Based on observation, interview, and record review, the licensee failed to post the required information related to the grievance procedure and reporting contact information for the Office of Ombudsman for Long-Term Care (OOLTC) and Mental Health and Developmental Disabilities, Minnesota Adult Abuse Reporting Center (MAARC), and Office of Health Facility Complaints (OHFC). 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 May 30, 2023, at 10:57 a.m., during the facility tour with licensed assisted living director (LALD)-C the surveyor could not locate the required postings. LALD-C stated they were not aware of the required postings which included: -Name, phone number and email contact information for the individuals who are responsible for handling resident complaints; -Contact information for the state and any regional Office of Ombudsman for Long-Term-Care and Office of Ombudsman for Mental Health and Developmental Disabilities -MAARC reporting contact information; and -OHFC reporting contact information. On May 30, 2023, at 1:50 p.m., LALD-C showed the surveyor they had created a form with the required posting information and would be posting it near the front entrance.	0 550		

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0 550	Continued From page 21 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post the 911 emergency phone number in common areas and near telephones provided by 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 of the residents).	0 640		

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0 640	Continued From page 22 The findings include: On May 30, 2023, at 10:57 a.m., during the facility tour with licensed assisted living director (LALD)-C, the surveyor could not locate the required 911 emergency phone number anywhere in the facility. On May 30, 2023, at 12:30 p.m., the surveyor observed the house phone (land line), located on the first floor living room did not have the required 911 posting. LALD-C stated it was for resident and staff use. On May 30, 2023, at 1:50 p.m., LALD-C stated they were unaware of the required 911 emergency phone number posting in the commons area and near phones provided by the facility and would post the number immediately. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 640		
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;	0 680		

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0 680	Continued From page 23 (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop a written emergency preparedness plan (EPP) with all the required content and post an emergency disaster plan prominently. 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: The licensee's undated Emergency Response, Reporting & Review Policy (licensee's EPP) was a template which lacked licensee's tailored information to include the following:	0 680		

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0 680	Continued From page 24 - establish and maintain a comprehensive EPP, reviewed/updated annually; - how they would coordinate with other health care facilities and community during an emergency or disaster (natural, man-made, facility, etc.), reviewed/updated annually; - documented date of reviews and updates; - community risk assessment with documentation; - consider duration of interruptions; - arrangements/contracts to re-establish utility services; - take an all-hazards approach; - categorize the various probable risks/hazards by likelihood of occurrence; - develop strategies for addressing community-based risks (evacuation plans, staffing/shortage, back-up plans); - missing resident plan; - an assessment of at-risk population's needs including maintaining independence, communication, transportation, supervision, and medical care; - must identify which staff would assume specific roles in another's absence through succession planning and delegation of authority; - a qualified person who is authorized, in writing, to act in the absence of the administrator; - a process for cooperation and collaboration with local, tribal, regional, State and Federal EP to maintain integrated response; - develop and implement EP policies/procedures and review/update annually; - develop/implement EP policies and procedures to address evacuation and shelter in place for staff and residents which must include: - alternate sources of energy to maintain temperature, safety and sanitary storage of provisions; - alternate sources of energy to fire detection,	0 680		

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0 680	Continued From page 25 extinguishing, alarms systems; - sewage and waste disposal; - a tracking system used to document locations of residents, staff, and relocation of staff; - develop policies and procedures to address safe evacuation from the facility including: - needs of evacuees; - staff responsibilities; - transportation; - alternate communication means; - develop policy and procedures for shelter in place for residents, staff and volunteers who remain at the facility; - develop policy and procedures to address: - systems of medical documentation that preserve resident information; - protects confidentiality; - secures/maintains availability of records; - develop policy and procedures must address use of volunteers including process and role for integration; - develop policy and procedures which address development and arrangements with other facilities or providers to receive residents in the event continuity of services cannot be provided; - develop policies and procedures which address role of the [licensee] under a waiver declared by the secretary in accordance with section 1135; - develop a written communication plan and review/update annually; - communication plan must include all the following names/contact information: - staff; - entities providing services under agreement; - residents' physicians; - other facilities; - volunteers; - communication plan must include contact information for: - MN Office of Ombudsman for LTC;	0 680		

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0 680	Continued From page 26 - other sources of assistance; - communication plan must include: - means to provide information about facility occupancy; - needs; - and ability to provide assistance; - authority having jurisdiction; - incident Command Center; - or designee; - communication plan must include a method for sharing information from emergency plan; - must develop and maintain EP training and testing program, review/update annually; - must conduct exercises to test the EP plan at least twice per year including unannounced staff drills using the EP; - must implement emergency and standby power systems based on their EP; and - if part of a healthcare system consisting of separately certified healthcare facilities and elects to have a unified and integrated EP, they may choose to participate. During interview on May 31, 2023, at approximately 1:00 p.m., licensed assisted living director (LALD)-C, stated they were unaware of the requirement but stated some information was added to the EPP after meeting with the environmental engineer during the survey. Before the end of the survey, LALD-C received information on the EPP requirements by the surveyor. The licensee's undated Assisted Living Required Postings and Disclosures policy indicated licensee would post the emergency disaster plan prominently. No further information provided	0 680		

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0 680	Continued From page 27 TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 700 SS=F	144G.43 Subdivision 1 Resident record (b) Resident records, whether written or electronic, must be protected against loss, tampering, or unauthorized disclosure in compliance with chapter 13 and other applicable relevant federal and state laws. The facility shall establish and implement written procedures to control use, storage, and security of resident records and establish criteria for release of resident information. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure residents' personal and health information was kept private for one of four 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) 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 May 30, 2023, at 10:57 a.m., during the facility tour with licensed assisted living director (LALD)-C, the surveyor observed four folders hanging on the wall near the main entrance, accessible to anyone entering, with each resident's name on it. R1's file contained a sheet	0 700		

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0 700	Continued From page 28 of paper entitled June 2023 Statement which included the following personal information: -June 2023 fees for monthly rent; -June 2023 additional fees for monthly services; -two-person transfer fee; and -Miscellaneous fees for disposable under pads and pull-ups. The folders for R2, R3 and R4 were empty. On June 1, 2023, at 2:30 p.m., LALD-C and registered nurse (RN)-A both stated the folders were used as a means of communication with the families and for providing them with information. Both stated they understood the privacy concern and would find a solution to keep the resident's private information secure. The licensee's Confidentiality of Resident Records and Information and Access to Records policy, undated, indicated, "Resident records and resident information will be kept confidential unless the resident or the resident's designated representative give permission for release of confidential information." No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 700		
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;	0 810		

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0 810	Continued From page 29 (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, record review and interview, the licensee failed to complete required employee evacuation drills. This 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	0 810		

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0 810	Continued From page 30 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). Findings include: A record review and interview were conducted on May 30, 2023, between approximately 2:00 p.m. and 2:30 p.m. with the Licensed Assisted Living Director (LALD)-D on the fire safety and evacuation plan, fire safety and evacuation training for the facility, and fire safety and evacuation drills for the facility. Record review indicated that evacuation drills for employees had not been performed every other month as required. During interview, LALD-D stated that facility employees participate in fire drills at their time of hire and then four times per year thereafter. Although this process met the two times per year requirement per employee, this method failed to meet the every other month requirement of the statute. This deficient condition was verified by LALD-D during the interview. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 820 SS=D	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use	0 820		

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0 820	Continued From page 31 does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to 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 ability to affect a limited number of staff and residents. This practice resulted in a level two distinct hazard violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). Findings include: On facility tour with the Licensed Assisted Living Director (LALD)-D between approximately 12:30 PM and 1:30 PM on May 30, 2023, it was observed that the door locking arrangements for the front and rear door exits of the facility were improperly in place. The observed exit doors require a code to exit that does not release upon activation of the fire alarm, fire sprinkler, or loss	0 820		

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0 820	Continued From page 32 of power. Any occupants would not be allowed to evacuate the facility in the event of an emergency under these conditions. This deficient condition was visually verified by LALD-D accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 820		
0 950 SS=C	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of 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	0 950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAMILY TREE CARE HOMES	2029 PALMER DRIVE NEW BRIGHTON, MN 55112

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0 950	Continued From page 33 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 include verbatim language giving residents the right to identify a designated representative for four of four residents (R1, R2, R3, R4). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On May 31, 2023, at approximately 8:00 a.m., licensed assisted living director (LALD)-C provided a blank copy of their Resident Agreement and stated it was the Resident Agreement currently in use with their residents. The blank Resident Agreement included space for a resident to select a designated representative on page 16, but lacked the required verbatim language on its own page separate from the contract. R1, R2, R3 and R4's signed Resident Agreements were reviewed and lacked the required verbatim language giving the right to identify a designated representative. On June 1, 2023, at 10:20 a.m., LALD-C stated	0 950		

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0 950	Continued From page 34 they were unaware of the required verbatim language requirement for a designated representative and would make the necessary changes. On June 1, 2023, at 2:30 p.m., LALD-C stated all of their current resident contracts were the same and none included the required verbatim language. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 950		
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the licensee's liability for health, safety, or personal property of a resident. 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	0 970		

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0 970	Continued From page 35 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: On May 31, 2023, at approximately 8:00 a.m., licensed assisted living director (LALD)-C provided a blank copy of their Resident Agreement and stated it was the Resident Agreement currently in use with their residents. The Resident agreement included the following waivers of liability: "28. INDEMNIFICATION Tenant will indemnify and hold harmless Landlord, its employees and agents from and against any and all claims, actions, damages, and liability and expense in connection with loss of life, personal injury or damage to property, arising from or out of the use by Tenant of the rented premises or any other part of Landlord's property, or caused wholly or in part by an act or omission of Tenant or Tenant's guests or agents." "30. LIABILITY Landlord is not liable to Tenant or Tenant's guests for any injury, death or property damage occurring in the Bedroom Unit or on Landlord's premises unless such injury, death or property damage occurs as the result of an equipment malfunction or hazardous conditions within the building not caused by Tenant or Tenant's guests. landlord is also not liable for any injury, death or damage occurring as the result of Tenant's receipt of health-related, supportive or other services from third party providers. Landlord may be liable to Tenant for its own negligent acts or those of its employees or agents. Unless caused by one of the aforementioned excepted reasons,	0 970		

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0 970	Continued From page 36 Tenant agrees to hold Landlord harmless from any and all claims for injuries, property damage or any other loss resulting from an accident or other occurrence in the Bedroom Unit or on Landlord s premises." R1, R2, R3 and R4's signed Resident Agreements were reviewed and included the above waivers of liability. On June 1, 2023, at 10:20 a.m., LALD-C stated they were unaware waivers of liability were not allowed in a resident agreement and would make the necessary changes. On June 1, 2023, at 2:30 p.m., LALD-C stated all of their current resident contracts were the same and included waivers of liability. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
01470 SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC);	01470		

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01470	Continued From page 37 (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) 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; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual	01470		

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01470	Continued From page 38 and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure one of two employees (registered nurse (RN)-A) received orientation to 144G licensing requirements. 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 included: RN-A was hired on July 1, 2018, and provided direct care services, complete resident assessments, and conducted training and supervision of unlicensed personnel (ULP). RN-A was the only RN employed with the licensee. RN-A's employee record did not contain documentation of completed required assisted living licensing and regulation orientation content before providing assisted living services to residents which included: - an overview of this chapter; -handling of emergencies and use of emergency services; - handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; and - consumer advocacy services of the Office of	01470		

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01470	Continued From page 39 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 On May 31, 2023, at 12:18 p.m., licensed assisted living director (LALD)-C indicated the training record already provided was all they had. LALD-C stated they (LALD-C and RN-A) completed the required training together on their online training program (Educare) but they were logged under the LALD-C's account so there was no record under RN-A's account. The licensee's undated Assisted Living & Assisted Living with Dementia Care Orientation-All Staff policy indicated all new staff must complete an orientation to assisted living facility licensing requirements and regulations before providing services to residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01470		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living	01620		

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01620	Continued From page 40 services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) utilized the uniform assessment tool for ongoing resident reassessment and monitoring for one of one resident (R1). In addition, the licensee failed to ensure the RN conducted a 14-day monitoring and reassessment no more than 14 calendar days from the start of service date for two of four 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:	01620		

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01620	Continued From page 41 R1 R1 was admitted to the licensee on May 31, 2021, with a diagnosis of dementia. R1's initial RN assessment was completed on June 1, 2021 and next assessment completed was a 90-day assessment on September 10, 2021. R1's record lacked a 14-day RN assessment, which should have been completed by June 15, 2021. R3 R3 was admitted to the licensee on December 17, 2022, with a diagnosis of dementia. R3's initial RN assessment was completed on December 18, 2022, and next assessment completed was a 90-day assessment on March 17, 2023. R3's record lacked a 14-day RN assessment, which should have been completed by January 1, 2023. R1 and R3's RN assessments did not include the following information required under Minnesota Rules Chapter 4659.0150 Subpart 2: -personal lifestyle preferences -advance health care directives and end-of-life preferences; -physical health status -allergies and sensitivities related to medication, seasonality, environment, and food; -review of medical, dental, and emergency room visits in the last 12 months, including visits to a primary health care provider, hepatizations, surgeries, and care from a post-acute care facility -a review of any reports from a physical	01620		

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01620	Continued From page 42 therapist, occupational therapist, speech therapist, or cognitive evaluations within the last 12 months -pain, including: -location, frequency, intensity, and duration; and -effectiveness of medication and nonmedication alternatives -hydration status and preferences; -risk indicators, including: -emergency evacuation ability; -complex medication regimen; -risk for dehydration, including history of urinary tract infections and current fluid intake pattern -who has decision making-making authority for the resident, including: -the presence of any advance health care directive or other legal document that establishes a substitute decision maker; and -the scope of decision-making authority of a substitute decision maker -the need for follow-up referrals for additional medical or cognitive care by health professionals On June 1, 2023, at 2:30 p.m., RN-A stated they were not sure if they were supposed to do 14-day RN assessments, at one point they were doing them but hadn't done them recently. RN-A stated all four of their residents probably didn't have the 14-day RN assessment completed. RN-A did not agree the RN assessments were missing content from the uniform assessment tool and felt it met requirements. The licensee's Initial and On-Going Nursing Assessment of Residents policy, undated, indicated: "1. A RN will complete the following comprehensive nursing assessments of the	01620		

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01620	Continued From page 43 resident's physical, mental, and cognitive needs as required: a. Pre-Admission Assessment b. 14-day assessment: completed up to 14-days after start of services c. Ongoing assessment: completed periodically but no less than every 90-days d. Change in resident condition" No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01640 SS=F	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan.	01640		

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01640	Continued From page 44 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to have signed service plans which identified specific services to be provided 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 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 R1's Care Plan, unsigned and undated, indicated R1 received services for activities of daily living (ADL's), transfers, toileting, medication management, behavior management, and meal assistance. R1's Individual Service Plan dated May 24, 2023, lacked a signature by the resident or resident representative and did not include agreed upon services to be provided. It included checked boxes as follows: -Review/update Medication Profile; -Review/update Functional assessment; -Review/update Psychosocial assessment; -Review/update Wellness assessment; and -Review/update ADL's assessment. R1's record included a June 2023 Statement which included a 2-person transfer fee for $750.00.	01640		

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01640	Continued From page 45 On May 31, 2023, at 9:58 a.m., ULP-B was observed providing services for R1. R2 R2's Care Plan, unsigned and undated, indicated R2 received services for ADL's, medication management, meal assistance, and toileting. R2's Individual Service Plan dated April 18, 2023, lacked a signature by the resident or resident representative and did not include agreed upon services to be provided. It included checked boxes as follows: -Review/update Medication Profile; -Review/update Functional assessment; -Review/update Psychosocial assessment; -Review/update Wellness assessment; and -Review/update ADL's assessment. R3 R3's Care Plan, unsigned and undated, indicated R3 received services for ADL's, medication management, meal assistance, and toileting. R3's Individual Service Plan dated March 17, 2023, had a signature by the resident or resident representative but did not include agreed upon services to be provided. It included checked boxes as follows: -Review/update Medication Profile; -Review/update Functional assessment; -Review/update Psychosocial assessment; -Review/update Wellness assessment; and -Review/update ADL's assessment. On June 1, 2023, at 2:30 p.m., registered nurse (RN)-A and licensed assisted living director (LALD)-C both stated they don't have cost or itemized services for residents, they have a flat	01640		

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01640	Continued From page 46 fee which included rent and services. Surveyor explained even so there still needed to be an agreement as to what services the residents agreed to receive. They acknowledged this and stated they will have residents or resident representatives sign the care plan which listed their services in the future. RN-A stated the service plans for all of their residents were handled the same way. The licensee's Content of Service Plans policy dated January 6, 2023, indicated: "5. Service plans will include: a. A description of the services provided b. Fees for services c. Frequency of each service according to resident assessment and resident preferences d. Schedule and methods of monitoring assessments e. Schedule and methods of monitoring staff providing services f. Contingency plan g. A contingency plan that includes: i. Action taken if the scheduled service cannot be provided ii. Information and method to contact the facility iii. Names and contact information of persons the resident wishes to have notified in an emergency iv. Names and contact information of persons the resident wishes to have notified if there is a significant adverse change in the resident's condition v. Identification of and information on who has authority to sign for the resident in an emergency vi. Circumstances in which emergency medical services are not to be summoned."	01640		

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	33728	A. BUILDING: _____ B. WING _____	05/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAMILY TREE CARE HOMES	2029 PALMER DRIVE NEW BRIGHTON, MN 55112

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01640	Continued From page 47 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01640		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by:	01650		

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01650	Continued From page 48 Based on observation, interview, and record review, the licensee failed to include required service plan content 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 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 R1's Care Plan, unsigned and undated, indicated R1 received services for activities of daily living (ADL's), transfers, toileting, medication management, behavior management, and meal assistance. R1's Individual Service Plan dated May 24, 2023, lacked the following service plan requirements: -a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; -the identification of staff or categories of staff who will provide the services; -the schedule and methods of monitoring assessments of the resident; -the schedule and methods of monitoring staff providing services; and -a contingency plan that includes: the action to be taken if the scheduled service cannot be provided, information and a method to contact the facility, the names and contact information of persons the resident wishes to have notified in an	01650		

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01650	Continued From page 49 emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency, and the circumstances in which emergency medical services are not to be summoned. R1's record included a June 2023 Statement which included a 2-person transfer fee for $750.00. On May 31, 2023, at 9:58 a.m., the surveyor observed ULP-B providing services for R1. R2 R2's Care Plan, unsigned and undated, indicated R2 received services for ADL's, medication management, meal assistance, and toileting. R2's Individual Service Plan dated April 18, 2023, lacked the following service plan requirements: -a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; -the identification of staff or categories of staff who will provide the services; -the schedule and methods of monitoring assessments of the resident; -the schedule and methods of monitoring staff providing services; and -a contingency plan that includes: the action to be taken if the scheduled service cannot be provided, information and a method to contact the facility, the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency,	01650		

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01650	Continued From page 50 and the circumstances in which emergency medical services are not to be summoned. R3 R3's Care Plan, unsigned and undated, indicated R3 received services for ADL's, medication management, meal assistance, and toileting. R3's Individual Service Plan dated March 17, 2023, lacked the following service plan requirements: -a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; -the identification of staff or categories of staff who will provide the services; -the schedule and methods of monitoring assessments of the resident; -the schedule and methods of monitoring staff providing services; and -a contingency plan that includes: the action to be taken if the scheduled service cannot be provided, information and a method to contact the facility, the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency, and the circumstances in which emergency medical services are not to be summoned. On June 1, 2023, at 2:30 p.m., registered nurse (RN)-A and licensed assisted living director (LALD)-C both stated they were not aware of the service plan content requirements. RN-A stated the service plans for all of their residents were handled the same way.	01650		

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01650	Continued From page 51 The licensee's Content of Service Plans policy dated January 6, 2023, indicated: "5. Service plans will include: a. A description of the services provided b. Fees for services c. Frequency of each service according to resident assessment and resident preferences d. Schedule and methods of monitoring assessments e. Schedule and methods of monitoring staff providing services f. Contingency plan g. A contingency plan that includes: i. Action taken if the scheduled service cannot be provided ii. Information and method to contact the facility iii. Names and contact information of persons the resident wishes to have notified in an emergency iv. Names and contact information of persons the resident wishes to have notified if there is a significant adverse change in the resident's condition v. Identification of and information on who has authority to sign for the resident in an emergency vi. Circumstances in which emergency medical services are not to be summoned." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01650		
01700 SS=F	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication	01700		

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01700	Continued From page 52 management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a medication management assessment was completed by the registered nurse (RN) to determine what medication management services would be provided and included identification and review in all required areas 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	01700		

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01700	Continued From page 53 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: R1 R1 was admitted to the licensee on May 31, 2021. R1's Care Plan indicated staff were to control and distribute all medications. R1`s May 2023, medication administration record included the following medications: -acetaminophen 500mg, take 2 tablets (1,000mg) by mouth (PO) two times daily for pain; -allopurinol 100mg, take 100mg PO at bedtime for gout; -atorvastatin 40mg, take 40mg PO every morning for cholesterol; -Depakote 125mg, take 2 capsules PO 2 times daily for mood; -ferrous gluconate 324mg, take 1 tablet PO once daily as a dietary supplement; -gabapentin 100mg, take 100mg PO twice daily for neuropathy; -melatonin 5mg, take 1 tablet PO at bedtime for insomnia; -multivitamin 1 tablet, take 1 tablet PO daily as a dietary supplement; -omeprazole 40mg, take 1 capsule PO 1 time daily for gastric acid secretion; -polyethylene glycol, take 8.5mg (half cap full) mixed with 4-8 ounces (oz) of water PO daily for constipation; -trazadone 50mg, take 1 tablet PO at bedtime for insomnia;	01700		

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01700	Continued From page 54 -trazadone 50mg, take 1/2 tablet (25mg) by mouth once daily at noon for agitation; -vitamin B-12 1000 micrograms (mcg), take 1 tablet PO daily; -vitamin C 250mcg, take 1 tablet PO daily with iron supplement for increased iron absorption; and -vitamin D3 1000 units (u), take 1 tablet PO daily. On May 31, 2023, at 9:58 a.m., the surveyor observed unlicensed personnel (ULP)-B administering medications to R1. R3 R3 was admitted to the licensee on December 17, 2022. R3's Care Plan indicated staff were to control and distribute all medications. R3's May 2023, medication administration record included the following medications: -acetaminophen 500mg, give 100mg PO 2 times daily for pain; -donepezil 10mg, give 1 tablet PO at bedtime for Alzheimer's Disease; -latanoprost 0.0005%, instill 1 drop into both eyes every evening for glaucoma; -melatonin 6mg, take 1 tablet PO at bedtime for insomnia; -pantoprazole 40mg, take 1 tablet PO twice a day; -Preservision 100, take 1 soft gel PO twice daily for eye health; -raloxifene 60mg, take 1 tablet PO once daily for osteoporosis; -trazadone 25mg, take 1 tablet PO at bedtime daily for insomnia; and -Vitron-C, take 1 tablet PO every other day as a supplement.	01700		

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01700	Continued From page 55 R1 and R3's record lacked evidence the RN conducted a face-to-face assessment with the resident and/or their representative to include a review of all medications the resident was known to be taking to include indications for use, side effects, contraindications, allergic or adverse reactions and actions to address these issues. On June 1, 2023, at 2:30 p.m., RN-A stated the licensee gets medication lists when residents come to the facility but the orders were not always signed. RN-A acknowledged a completed medication management assessment should have included a medication reconciliation at the time of admission to make sure medications had orders and were being taken correctly prior to administering medications. RN-A stated this was true of all of their resident's medication records. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01700		
01760 SS=F	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	01760		

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01760	Continued From page 56 administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to include medication descriptions for unlicensed personnel (ULP) to reference when administering medications. Further, medication administration documentation did not identify which medications were administered by ULPs for two of two residents (R1, R4). This had the potential to affect all residents receiving medication administration 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 May 30, 2023, at 10:08 a.m., during the entrance conference registered nurse (RN)-A stated she does medications setups in pillboxes for all of their residents and unlicensed personnel administer the medications from the pillbox. On May 31, 2023, at 9:58 a.m., the surveyor observed ULP-B administering medications to R1. R1 R1's Individual Service Plan and Care Plan were both undated. The Care Plan indicated staff were	01760		

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01760	Continued From page 57 to control and distribute all medications due to dementia. R1's Medication Administration Tracking form for May 2023, was initialed by the administering staff members. The form did not include a medication description, number of pills being taken, or orders for the administering staff member to reference when administering medication. R4 R4's Individual Service Plan and Care Plan were both undated. The Care Plan did not indicated staff were to provide medication management services despite the service being provided. R4's Medication Administration Tracking form for May 2023, was initialed by the administering staff members. The form did not include a medication description, number of pills being taken, or orders for the administering staff member to reference when administering medications. On June 1, 2023, at 12:30 p.m., ULP-B stated they signed off on medication administration on the Medication Administration Tracking form. ULP-B stated ULPs did not know which medications they were administering to residents, they only documented if the pillbox medications had been given in general and had no way of knowing how many pills were supposed to be administered. They had no way to identify which medications were which in the event a pill was dropped or a resident refused a medication. ULP-B stated if something were to happen, they could call the nurse or use a drug identifier app, but there wasn't a formal procedure. On June 1, 2023, at 2:30 p.m., RN-A stated ULPs were to administer the medications from the	01760		

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01760	Continued From page 58 pillbox which she had setup and signed off on in the medication administration record (MAR). The ULPs would sign off on the Medication Administration Tracking form after they had administered the medications from the pillbox but did not sign off on what individual medications they administered. RN-A stated the documentation system used was the same for all four residents who lived in the facility. RN-A stated ULPs did not know what was being administered and acknowledged there wasn't anything setup for them to be able to identify the pills being given, they would have to contact the nurse if a problem occurred or if a resident didn't want a certain pill. The licensee's Documentation of Medication, Treatment and Therapy by Unlicensed Personnel policy, undated, indicated: "1. Unlicensed personnel that will provide assistance with medication, treatment and therapy administration will be trained and competency tested by the RN on the following: a. The complete procedures for checking the resident's medication administration record and medication profile, treatment and therapy profile and any additional information. b. Infection control precautions that must be followed when administering medications, treatment and therapy. c. Preparation of the medication for the resident when necessary; d. Administration of the medication, treatment and therapy to the resident (or assistance with self-administration); e. Documentation, after assistance with self-administration of medications or medication, treatment and therapy administration, consistent with our facility's procedures for documenting the MAR.	01760		

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01760	Continued From page 59 f. The procedure for staff to notify the RN of any medications or dietary supplements that are being used by the resident and that are not included in the assessment for med management services. 2. Medications, treatment and therapy always need to be administered according to the "6 Rights" a. Right person b. Right medication, treatment or therapy c. Right time d. Right route (by mouth, eye drops, to the skin, etc.) e. Right dose (how many milligrams, drops, etc) f. Right chart/record to document that the medication, treatment and therapy was taken." No further information provided TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
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 four residents (R1, R3). This practice resulted in a level two violation (a	01820		

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01820	Continued From page 60 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's Care Plan, unsigned, indicated R1 received services for medication management. R1's record lacked signed provider orders for the following medications identified on R1's May 2023, medication administration record (MAR), used by registered nurse (RN)-A for medication setup and administration documentation for the following medications: -acetaminophen 500mg, take 2 tablets (1,000mg) by mouth (PO) two times daily for pain; -allopurinol 100mg, take 100mg PO at bedtime for gout; -atorvastatin 40mg, take 40mg PO every morning for cholesterol; -Depakote 125mg, take 2 capsules PO 2 times daily for mood; -ferrous gluconate 324mg, take 1 tablet PO once daily as a dietary supplement; -gabapentin 100mg, take 100mg PO twice daily for neuropathy; -melatonin 5mg, take 1 tablet PO at bedtime for insomnia; -multivitamin 1 tablet, take 1 tablet PO daily as a dietary supplement; -omeprazole 40mg, take 1 capsule PO 1 time daily for gastric acid secretion; -polyethylene glycol, take 8.5mg (half cap full)	01820		

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	33728	A. BUILDING: _____ B. WING _____	05/31/2023

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01820	Continued From page 61 mixed with 4-8 ounces (oz) of water PO daily for constipation; -trazadone 50mg, take 1 tablet PO at bedtime for insomnia; -trazadone 50mg, take 1/2 tablet (25mg) by mouth once daily at noon for agitation; -vitamin B-12 1000 micrograms (mcg), take 1 tablet PO daily; -vitamin C 250mcg, take 1 tablet PO daily with iron supplement for increased iron absorption; and -vitamin D3 1000 units (u), take 1 tablet PO daily. R3 R3's Care Plan, unsigned, indicated R3 received services for medication management. R3's record lacked signed provider orders for the following medications identified on R3's May 2023, medication administration record (MAR), used by registered nurse (RN)-A for medication setup and administration documentation for the following medications: -acetaminophen 500mg, take 1000mg PO two times a day for pain and discomfort; -PreserVision AREDS2+ 100, take 1 soft gel PO twice daily for eye health; R3's record did however have a signed medication order dated March 25, 2023, for the following medication which was not on R3's MAR: -loperamide hydrochloride (HCL) 2mg, 2 tablets after the first loose stool, 1 tablet after each subsequent loose stool, but no more than 4 tablets in 24 hours. On May 31, 2023, at 10:14 a.m., the surveyor observed unlicensed personnel (ULP)-B administering medications to R1 from a pillbox previously setup by RN-A.	01820		

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01820	Continued From page 62 On June 1, 2023, at 10:24 a.m., RN-A stated they could not find all of R3's provider orders for their medications. At 10:35 a.m., RN-A provided addition provider orders from Bluestone (healthcare provider platform) and stated they could not locate the remaining orders for R3. On June 1, 2023, at 2:30 p.m., RN-A stated they were unable to locate any provider orders for R1 and any further orders for R3. RN-A stated they didn't know the orders needed to be signed annually. They get medication lists when residents come to the facility, but they were not always signed orders. RN-A stated they oversaw making sure medication orders were in place. RN-A stated they were aware of the requirement to have providers orders for all medications and would need to address this issue when taking a new admission. The licensee's Documentation of Medication, Treatment and Therapy Management Services policy, undated, indicated, "Receiving and Requesting Prescriptions and Refills. The nurse will document actions to implement a new prescription when it is received, and actions to request and obtain needed refills for residents, including communications with the prescriber, pharmacy, resident and/or resident's representative or family." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		
01890 SS=D	144G.71 Subd. 20 Prescription drugs	01890		

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01890	Continued From page 63 A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications included required patient identifying labels, medication administration instructions, and an opened-on date for one of four residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: R3's Care Plan, unsigned, indicated R3 received services for medication management. R3's signed medication orders dated January 26, 2023, indicated R3 took the following medications: -latanoprost 0.005% eye drops, instill 1 drop by ophthalmic (in the eye) route every day into affected eyes in the evening. On June 1, 2023, at 10:04 a.m., the surveyor observed the facility medication closet with unlicensed personnel (ULP)-B. R3's latanoprost	01890		

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01890	Continued From page 64 0.005% eye drops bottle was in R3's medication storage cubby. The bottle lacked both an opened-on date and pharmacy labeling. ULP-B acknowledged without the labeling there was no way to know who the medication belonged to or when it had been opened. On June 1, 2023, at 2:30 p.m., registered nurse (RN)-A stated the expectation was for all medications to have resident identifying information from the pharmacy and an opened-on date for eye drops. RN-A stated they were in the process of correcting this problem immediately. The latanoprost 0.005% eye drops 125 micrograms (mcg)/2.5 milliliters (ml) solution manufacturers packaging (box) indicated once the bottle was opened it could be stored at room temperature (77 degrees Fahrenheit (F)) for up to six weeks. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
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	01970		

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01970	Continued From page 65 by: Based on observation, interview, and record review, the licensee failed to obtain a prescriber's order for continuous positive airway pressure (CPAP) for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 admitted to licensee on May 31, 2021. R1's medical record included diagnoses of dementia, sleep apnea (breathing pauses during sleep), type 2 diabetes, falls, and arthritis. R1 received assistance with medication administration, CPAP, transfers, personal cares, bathing, and meals. During observation on May 31, 2023, at 9:58 a.m., ULP-B helped R1 remove the CPAP and began assisting with personal cares. R1's ULP CPAP administration and removal document dated May 1, 2023, through May 31, 2023, included documentation of CPAP application and removal. R1's After Visit Summary (AVS) dated June 2, 2021, listed CPAP under the medication list but the AVS was not signed by the provider either by hand or electronically.	01970		

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01970	Continued From page 66 R1's provider orders signed December 5, 2022, ordered an in-home sleep evaluation for CPAP evaluation and adjustment for existing machine as needed. R1's medical record lacked orders to include frequency, duration, and other information needed to administer the treatment. During an interview on June 1, 2023, at 2:30 p.m., registered nurse (RN)-A agreed the referral for CPAP evaluation was not a valid order. A policy on treatment management was requested but only one for treatment documentation was provided. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970		
02110 SS=F	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed;	02110		

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02110	Continued From page 67 (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure policies and procedures for assisted living with dementia care (ALFDC) were provided to residents and the residents' legal and/or designated representatives at the time of move in for four of four residents (R1, R2, R3, R4). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all	02110		

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02110	Continued From page 68 the residents). The findings include: R1 was admitted to the licensee on May 31, 2021. R2 was admitted to the licensee on July 20, 2022. R3 was admitted to the licensee on December 17, 2022. R4 was admitted to the licensee on April 3, 2021. R1, R2, R3 and R4's records lacked evidence the licensee provided the resident, or residents' designated representative, with the required policies and procedures for the ALFDC license. On June 1, 2023, at 10:20 a.m., licensed assisted living director (LALD)-C stated they did not develop all of the required dementia care policies required under the ALFDC licensure and did not have an acknowledgement of receipt form available for residents and/or the residents' legal and designated representatives to sign. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02110		
02310 SS=I	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care	02310		

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02310	Continued From page 69 standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care, medical or nursing standards for three of three residents, one of whom utilized hospital bed rails (R1) and two of whom utilized consumer bed rails (R2, R3). 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: R1 R1 had a diagnosis of dementia and falls. R1's Individualized Service Plan, signed but not dated, and Care Plan indicated R1 received services for one and two person transfers, dressing, medication management, personal cares, toileting, and meal setup. It further indicated, "Pt (patient) can get out with assist of 1, bed raised to a high position and using the bed rail." The Care Plan offered no additional information or instruction related to R1's bed rail. On May 30, 2023, at 10:57 a.m., during the facility tour the surveyor observed R1's hospital bed had two half-bed rails in the lower position affixed to the bed. Licensed assisted living director	02310	The immediacy for the correction order identified on May 31, 2023, issued for SL33728015-0, tag identification 2310, is removed as of June 1, 2023. The scope and level remain unchanged.	

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02310	Continued From page 70 (LALD)-C stated the bed rails were only up and in use when staff transferred or assisted R1 in bed so R1 could participate, the bed rails were otherwise always in the lowered position. The bed rails were firmly attached to the hospital bed. On May 31, 2023, at 8:20 a.m., the surveyor observed R1 sleeping in bed with both bed rails in the lowered position. R1's Bed Rail Risk Assessments, undated, lacked resident specific information and assessment for the hospital bed rail to include: - Purpose and intention of the bed rail; - Measurements; - The resident's bed rail use/need assessment; - Risk vs. benefits discussion (individualized to each resident's risks); - The resident's preferences; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements. R2 R2 had a diagnosis of Alzheimer's, stress cardiomyopathy, and frequent urinary tract infections. R2's Individualized Service Plan, signed but not dated, and Care Plan indicated R2 received services for toileting, dressing, meal setup, and personal cares. It further indicated, "Pt is able to independently reposition self in bed and while in chair. Pt does use bed rail for assistance with repositioning/getting up." The Care Plan offered no additional information or instruction related to R2's bed rail. On May 30, 2023, at 10:57 a.m., the surveyor	02310		

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02310	Continued From page 71 observed during the facility tour R2's bed had a white upside-down U-shaped consumer bed rail affixed to the right side of the bed with two horizontal bars between the U-shape, the bed rail was firmly attached. On May 31, 2023, at 7:59 a.m., the surveyor observed R2's consumer bed rail. There was a silver manufacturer sticker which had a most if it scratch/peeled off. R2's Bed Rail Risk Assessments, undated, lacked resident specific information and assessment for the consumer bed rail to include: - Purpose and intention of the bed rail; - Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail; - The resident's bed rail use/need assessment; - Risk vs. benefits discussion (individualized to each resident's risks); - Installation and use according to manufacturer's guidelines; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements. R3 R3 had a diagnosis dementia, history of falls, and vertigo. R3's Individualized Service plan, signed but not dated, and Care Plan indicated R3 received services for standby assist, toileting, bathroom reminders, and housekeeping. It further indicated, "Staff remind/assist with adaptive equipment such as lift chair and use of grab bars." The Care Plan offered no additional information or instruction related to R3's bed rail.	02310		

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02310	Continued From page 72 On May 31, 2023, at 8:03 a.m., the surveyor observed R3's bed had a black upside-down U-shaped consumer bed rail covered with a fitted mesh cover affixed to the left side of the bed, the bed rail was firmly attached. R3's Bed Rail Risk Assessments, undated, lacked resident specific information and assessment for the consumer bed rail to include: - Purpose and intention of the bed rail; - Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail; - The resident's bed rail use/need assessment; - Risk vs. benefits discussion (individualized to each resident's risks); - Installation and use according to manufacturer's guidelines; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements. On May 31, 2023, at 7:27 a.m., registered nurse (RN)-A stated they did not have measurements for R1's bed rail on the zones of entrapment. RN-A stated the bed rails for R1 were only up when staff were present, he was able to help reposition himself and get out of bed with use of the bed rails. On May 31, 2023, at 7:36 a.m., LALD-C stated R1's bed rails were only up when providing cares and didn't understand why measurements would be required in R1's situation. On May 31, 2023, at 7:39 a.m., RN-A stated they	02310		

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02310	Continued From page 73 did not know entrapment zone measurements required by the FDA. They also questioned why measurements would be required if the bed rails were only in the up position when staff were present. On May 31, 2023, at 7:41 a.m., RN-A stated they did not have any manufacturer information for either R2 or R3's consumer bed rails nor had they consulted any manufacturer information for proper installation. RN-A stated they weren't aware of who the manufacturers were for both R2 and R3's consumer bed rails, the families were the ones who brought them into the home. RN-A stated she did not know bed rail requirements. RN-A asked what they were supposed to measure on the hospital bed rail, surveyor explained the entrapment zones must be within measurement guidelines set by the FDA due to bed rails high risk of injury or death. On May 31, 2023, at 7:50 a.m., LALD-C provided the risk versus benefits forms signed by resident representatives for R2 and R3, they stated they could not locate one for R1. The FDA, A Guide to Bed Safety, dated 2000, and revised April 2010, indicated following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe."	02310		

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(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
02310	Continued From page 74 The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently Asked Questions (FAQs) indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." The MDH website indicated for consumer bed rails, the licensee must include in their documentation: - Purpose and intention of the bed rail; - Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail; - The resident's bed rail use/need assessment; - Risk vs. benefits discussion (individualized to each resident's risks); - The resident's preferences; - Installation and use according to manufacturer's guidelines; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements". Additionally, the MDH website indicated for hospital-style bed rails, the licensee must include in their documentation: - Purpose and intention of the bed rail; - Measurements;	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33728	A. BUILDING: _____ B. WING _____	05/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAMILY TREE CARE HOMES	2029 PALMER DRIVE NEW BRIGHTON, MN 55112

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02310	Continued From page 75 - The resident's bed rail use/need assessment; - Risk vs. benefits discussion (individualized to each resident's risks); - The resident's preferences; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements. The licensee's Bed Rail Assessment forms used for R1, R2 and R3 indicated, "This risk assessment tool is an aide for health care staff. Please reassess every six months and as needed. This tool should be used in addition to the local guidelines on the safe use of bed rails and fall prevention. This tool does not replace critical thinking and clinical judgement." The licensee's Devices and Device Assessment policy, no date of development and last reviewed by LALD-C, included FDA requirements for measurements and entrapment zones and indicated: "POLICY: 1. Due to the risk of injury related to the use of physical devices, such devices will only be used after an assessment has been completed to determine the risks and benefits of this use. 2. The resident/responsible party will be educated regarding the risks and benefits of physical devices. Physical devices will be reviewed for safety and used according to manufacturer's recommendations. 3. Continued use of physical devices will be assessed at least every 90 days or with significant change to determine if the device is still needed to enhance the resident's safety and/or bed mobility.	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33728	A. BUILDING: _____ B. WING _____	05/31/2023

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02310	Continued From page 76 4. If the physical device restricts a resident's freedom of movement, it constitutes a restraint, and our facilities are restraint free. Physical devices that do not restrict the resident's freedom of movement and are used to assist the resident/client in bed mobility are not restraints. 5. Physical devices include, but are not limited to, side rails (half or full); grab bars, halo bars, positioning poles. 6. Grab bars that are either placed/attached or strapped between the mattress and box spring or bed frame are not allowed in our building without the inspection of the RN or Assisted Living Director. PROCEDURE: 1. If the resident expresses the desire to use a device or a device is in use / recommended, a nurse will complete a device assessment at the time of move in, upon hospital return, change in condition, and / or upon discovery of a rail. 2. The licensed nurse or designee will review the risks and benefits of device use and potential device alternatives with the resident and/or responsible party. 3. Devices will be installed as appropriate for the type of bed: a. For hospital beds: Device will be installed per FDA guidelines b. For non-hospital beds: Devices will be installed according to the device manufacturer's instructions. 4. Documentation will be entered in the resident's record to include: a. Results of the assessment b. Discussion with resident/responsible party regarding risks and benefits and alternatives considered / recommended c. Decision made/outcome of discussion. 5. Staff will be educated to report to a licensed nurse immediately if the device is found to be	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33728	A. BUILDING: _____ B. WING _____	05/31/2023

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02310	Continued From page 77 loose or malfunctioning. 6. Physical devices will be assessed for safety during each re-assessment. If there are any safety issues identified, the Director of Health Services, or Housing Director will be notified immediately. 7. Assisted Living Director or RN will inspect bed and mattress for zone safety at least every 90 days. 8. Assisted living Director or RN will inspect bed devices at least every 90 days. If the device has become loose/ unstable in any way it will be removed and the responsible party will be notified. If the RN or Assisted living Director are unable to securely fasted. 9. Two times per year the Clinical Nurse Supervisor, or designee, will check the FDA website for recalls on bed assistive devices through the FDA Data Base 10. If a licensed nurse, or other designee believes that the assistive device places the resident at risk for harm (EX: Unable to use safely etc) it will be removed and the family will be notified. No further information provided." TIME PERIOD FOR CORRECTION: IMMEDIATE	02310		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision.	03090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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03090	Continued From page 78 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure the required verbatim notice was posted at the facility main entrance to disclose electronic monitoring activity. This practice resulted in a level one violation (a violation that has not 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: On May 30, 2023, at 10:00 a.m., surveyor entered the facility and observed the main entrance and interior commons areal which lacked the required signage for electronic monitoring verbatim notice to visitors. On May 30, 2023, at 10:57 a.m., during the facility tour no electronic monitoring signage could be found. Licensed assisted living director (LALD)-D stated they did not have the required electronic monitoring signage posted in the facility. The licensee's Assisted Living Required Posting and Disclosures policy, undated, indicated, "Other postings for HR, Electronic Monitoring & Fair Housing as required." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	03090		

DEPARTMENT OF HEALTH

Type: Full
Date: *05/30/23*
Time: 12:24:57
Report: 1036231134

Food and Beverage Establishment Inspection Report

Location:
Family Tree Care Homes
2029 Palmer Drive
New Brighton, MN55112
Ramsey County, 62

Establishment Info:
ID #: 0037617
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 6513405583
ID #:

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

The following orders were issued during this inspection.

3-500C Microbial Control: date marking

3-501.17B ***** Priority 2 *****

MN Rule 4626.0400B Mark the refrigerated, ready-to-eat, TCS food prepared and packaged in a processing plant and opened and held for more than 24 hours in the food establishment using an effective method to indicate the date by which the food must be consumed on the premises, sold, or discarded. The date must not exceed the manufacturer's use-by-date.

NO DATE LABEL ON OPENED BAGS OF SHREDDED CHEESE IN FRIDGE. ISSUE CORRECTED ON SITE.

Comply By: 05/30/23

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 CHLORINE TEST STRIPS AVAILABLE TO TEST CONCENTRATION OF BLEACH/WATER SANITIZATION MIXTURE. MDH PROVIDED A FEW STRIPS UNTIL SOME CAN BE OBTAINED.

Comply By: 06/06/23

4-500 Equipment Maintenance and Operation

4-501.116 ***** Priority 2 *****

MN Rule 4626.0815 Use the sanitizer test kit or other device to accurately measure the concentration of the sanitizing solution.

KITCHEN SANITIZER SPRAY BOTTLE HAD A CHLORINE CONCENTRATION OF >200 PPM. MAINTAIN A CHLORINE CONCENTRATION OF 50-100PPM.

Comply By: 06/06/23

2-300 Personal Cleanliness

2-301.12C

MN Rule 4626.0070C Food employees must avoid recontamination of their hands after handwashing by using a disposable paper towel or similar clean barrier to close faucet handles on a handwashing sink or the handle on a restroom door.

OBSERVED EMPLOYEE WASH HANDS, DRY HANDS, THEN TURN OFF FAUCET WITH BARE HAND. MDH REVIEWED PROPER HANDWASHING TECHNIQUES WITH STAFF.

Comply By: 05/30/23

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

3-305.11A

MN Rule 4626.0300A Store all food in a clean, dry location; where it is not exposed to splash, dust or other contamination; and at least 6 inches above the floor.

OBSERVED SOME FOOD STORED ON THE FLOOR IN THE DRY FOOD STORAGE PANTRY. COMPLY WITH ABOVE RULE.

Comply By: 06/06/23

Surface and Equipment Sanitizers

Chlorine: = >200PPM at Degrees Fahrenheit
Location: KITCHEN SANI SPRAY BOTTLE
Violation Issued: No

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

Food and Equipment Temperatures

Process/Item: Cold Hold/MILK
Temperature: 38 Degrees Fahrenheit - Location: KITCHEN FRIDGE
Violation Issued: No

Process/Item: Ambient Temp
Temperature: 1 Degrees Fahrenheit - Location: KITCHEN FREEZER
Violation Issued: No

Process/Item: Ambient Temp
Temperature: 0 Degrees Fahrenheit - Location: BASEMENT FREEZER
Violation Issued: No

Type: Full
Date: *05/30/23*
Time: 12:24:57
Report: 1036231134
Family Tree Care Homes

Food and Beverage Establishment Inspection Report

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

THIS INSPECTION WAS CONDUCTED IN CONJUNCTION WITH MDH HEALTH REGULATORY DIVISION (HRD) SURVEY. SURVEYOR FROM HRD WAS JOEY KEEN. INSPECTION CONDUCTED IN PRESENCE OF LEE PANZER, THE PERSON IN CHARGE. ALL VIOLATIONS WERE DISCUSSED WITH PERSON IN CHARGE AND HRD EVALUATOR DURING INSPECTION.

THIS FACILITY DOES NOT HAVE COMMERCIAL GRADE ANSI EQUIPMENT. ALL FOOD MUST BE SERVED THE SAME DAY IT IS PREPARED, AND LEFTOVERS CAN NEVER BE SAVED.

THESE ADDITIONAL TOPICS WERE DISCUSSED WITH THE PERSON IN CHARGE:
- EMPLOYEE ILLNESS EXCLUSION
- HAND WASHING PROCEDURE
- NO BARE HAND CONTACT WITH RTE FOOD
- FULLY COOKING FOOD FOR HIGH RISK POPULATIONS
- THERMOMETER USE AND CALIBRATION
- ANSI 184 STANDARD FOR RESIDENTIAL DISH WASHER
- PEST MANAGEMENT

FOR CORRECT BY DATES REFER TO COMPLETE REPORT ISSUED BY HRD.

**IF ANY RESIDENTS COMPLAIN OF ILLNESS, CONTACT THE MINNESOTA DEPARTMENT OF HEALTH AND PROVIDE THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER TO THE CUSTOMER. THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER IS 1-877-366-3455.

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

I acknowledge receipt of the inspection report number 1036231134 of 05/30/23.

Certified Food Protection Manager: LEE J. PANZER

Certification Number: FM97525 Expires: 02/27/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
LEE PANZER
KITCHEN MANAGER

Signed: _____
Jeff Johanson