Electronically Delivered

August 3, 2022

Administrator
Inspired Senior Living Of Hanover
10875 Settlers Lane
Hanover, MN 55341

RE: Project Number(s) SL32913015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on June 29, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health 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.

The enclosed State Form documents the state licensing orders. The Department of Health 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 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.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes 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 Department of Health 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 (a)(5)(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 evaluation:

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, no immediate fines are assessed.

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up evaluations. The licensee is not required to submit a plan of correction 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 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 Department of Health within 15 calendar days of the correction order receipt date.

A state licensing 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 general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

Please address your cover letter for general reconsideration requests to:
Reconsideration Unit
Health Regulation Division

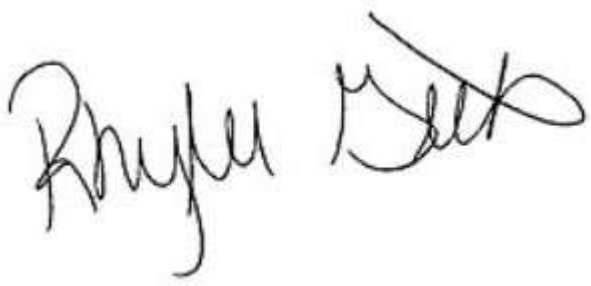
Free from Maltreatment reconsideration requests should be addressed to:
Reconsideration Unit
Health Regulation Division

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

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

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,



Rhylee Gilb, Supervisor
State Rapid Response Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64970
St. Paul, MN 55164-0970
Telephone: 218-232-8285 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
	32913	A. BUILDING: _____ B. WING _____	06/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INSPIRED SENIOR LIVING OF HANOVER	10875 SETTLERS LANE HANOVER, MN 55341

(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 Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. *****REVISED***** INITIAL COMMENTS: #SL32913015 On June 27, 2022 through June 29, 2022, the Minnesota Department of Health conducted a Change of Ownership (CHOW) survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 21 residents receiving services under the provider's Assisted Living with Dementia Care license. The following immediate correction order is issued for #SL32913015, tag 0110. Non-immediate correction orders for SL32913015 are issued.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 110 SS=F	144G.10 Subdivision 1a Assisted living director license required	0 110		6/28/22

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0 110	Continued From page 1 Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to employ a licensed assisted living director (LALD). This practice had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). Twenty one residents lived at the licensee. Findings include: Administrator (AD)-B's hire date was May 2, 2022. On June 27, 2022 at 9:30 a.m., during an entrance conference, AD-B said she is the housing director and licensed assisted living director, but then said she had applied for the LALD certification and was taking classes. AD-B said thought the regional director was an LALD but she would check and let the surveyor know. On June 28, 2022 at 8:51 a.m., AD-B said the regional director was not an LALD, she'd been mistaken. AD-B provided the surveyor with a copy of AD-B's payment confirmation from the	0 110		

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0 110	Continued From page 2 Minnesota Board of Nursing Home Administrators, dated June 28, 2022. The confirmation was for an AL license. A policy titled Employment Assisted Living Director, dated November 1, 2021, indicated Inspired Living of Hanover is required to have an assisted living director license or permitted by the Board of Executives for Long Term Services and Support (BELTSS). TIME PERIOD TO CORRECT: IMMEDIATE	0 110		
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 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;	0 470		

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0 470	Continued From page 3 (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 a staffing plan that included an evaluation of the appropriateness of staffing levels at least twice a year. The licensee did not post the staffing plan in a central location for residents. This had the ability to effect all 21 residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). Findings include: The licensee held an Assisted Living with Dementia License, effective date August 1, 2021 through July 31, 2022 with a resident capacity of 26. The resident census for June 27, 2022 was 21. During the change of ownership (CHOW) entrance conference on June 27, 2022 at 10:00 a.m., the Director of Wellness (DW)-A and the housing manager (HM)-B said the regional director did the staffing plans but did not know when or how the staffing plan was evaluated. During the entrance conference DW-A said the daily staffing plan and schedule were not posted	0 470		

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0 470	Continued From page 4 in a central location for residents. During a tour of the licensee on June 27, 2022 a 10:50 a.m., the MDH surveyor did not observe a staffing plan or staffing schedule posted in common areas. The MDH surveyor requested a staffing plan and a staffing plan policy but only received the staffing plan for the week of June 27 to July 3, 2022. TIME PERIOD TO CORRECT: Twenty-one (21) Days	0 470		
0 500 SS=F	144G.41 Subd. 2 Policies and procedures Each assisted living facility must have policies and procedures in place to address the following and keep them current: (1) requirements in section 626.557, reporting of maltreatment of vulnerable adults; (2) conducting and handling background studies on employees; (3) orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; (4) handling complaints regarding staff or services provided by staff; (5) conducting initial evaluations of residents' needs and the providers' ability to provide those services; (6) conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate;	0 500		

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0 500	Continued From page 5 (7) orientation to and implementation of the assisted living bill of rights; (8) infection control practices; (9) reminders for medications, treatments, or exercises, if provided; (10) conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards; (11) ensuring that nurses and licensed health professionals have current and valid licenses to practice; (12) medication and treatment management; (13) delegation of tasks by registered nurses or licensed health professionals; (14) supervision of registered nurses and licensed health professionals; and (15) supervision of unlicensed personnel performing delegated tasks. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure they met the requirements for licensure by attesting the managerial officials in charge of day-to-day operations had assisted living licensure policies and procedures in place as required and kept them current. This had the potential to affect all residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	0 500		

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0 500	Continued From page 6 Findings include: The licensee held an Assisted Living with Dementia License, effective date August 1, 2021 through July 31, 2022 with a resident capacity of 26. The resident census for June 27, 2022 was 21. During the change of ownership (CHOW) entrance conference on June 27, 2022 at 10:00 a.m., the housing manager (HM)-B stated she was familiar with the current assisted living laws and regulations but she was new to the job. The licensee failed to have the following policies and procedures implemented: - orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; - conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate; - conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards; - supervision of registered nurses and licensed health professionals Refer to MN 144G.63 Subdivision 1. The licensee failed to ensure staff who provided and supervised direct services completed orientation to assisted living facility licensing requirements	0 500		

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0 500	Continued From page 7 and regulations before providing services to residents Refer to MN 144G.63 Subd. 3. The licensee failed to ensure staff providing assisted living services must be oriented specifically to each individual resident and the services to be provided Refer to MN 144G.60 Subd. 4. The licensee failed to ensure one of one unlicensed personnel successfully completed a training and competency evaluation appropriate to the services provided by the licensee and the topics listed in section 144G.61. Refer to MN 144G.42 Subd. 6. (b).The licensee failed to develop and implement an individual abuse prevention plan (IAPP) for three of five residents: R2, R3 and R5. Refer to MN 144G.42 Subd. 2. The licensee failed to engage in quality management activities and failed to provide documentation of any quality management activities. Refer to MN 144G.42 Subd. 9.The licensee failed to establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the Centers for Disease Control (CDC) Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The facility must maintain written evidence of compliance with this subdivision. The licensee failed to ensure documentation of baseline TB screening for one of four staff. TIME PERIOD TO CORRECT: Twenty-one (21)	0 500		

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0 500	Continued From page 8 DAYS	0 500		
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to engage in quality management activities and failed to provide documentation of any quality management activities. This had the potential to effect all 21 residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). Findings include: The licensee held an Assisted Living with	0 580		

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0 580	Continued From page 9 Dementia License, effective August 1, 2021 through July 31, 2022 and the resident capacity was 26. The resident census for June 27, 2022 was 21. During the change of ownership (CHOW) entrance conference on June 27, 2022 at 10:00 a.m., the Director of Wellness (DW)-A said she was not sure about any quality management policies or meetings, she was not sure the previous owners left any records but she and housing manager (HM)-B would check. On June 28, 2022 at 8:51 a.m., DW-A said the former owners did not leave much information behind and she and HM-B are still learning the process. DW-A said she could not find any quality management information or policies. Time Period to Correct: TWENTY-ONE (21) DAYS	0 580		
0 630 SS=E	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse.	0 630		

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0 630	Continued From page 10 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement an individual abuse prevention plan (IAPP) for three of five residents (R2, R3 and R5) records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). Findings include: The licensee held an Assisted Living with Dementia License, effective date August 1, 2021 through July 31, 2022 and the resident capacity was 26. The resident census for June 27, 2022 was 21. During the change of ownership (CHOW) entrance conference on June 27, 2022 at 10:00 a.m., the Director of Wellness (DW)-A stated she is responsiblie for all resident assessments. R2 R2's diagnoses include unspecified convulsions, atrial fibrillation and difficulty walking. R2's service agreement, dated November 23, 2021, indicated R2 received assistance with activities of daily living (ADLs), medication administration, and cueing for social activities.	0 630		

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0 630	Continued From page 11 A Minnesota Adult Abuse Report Center (MAARC) report, dated May 17, 2022, filed by the licensee, detailed an incident where R2 reported to staff she was slapped by another resident with significant dementia who wanted to sit in a chair already occupied by an unknown resident. R2's records lacked an IAPP. R3 R3's diagnoses included unspecified dementia and cardiac arrhythmia. R3's service agreement, dated November 11, 2021, indicated R3 received wellness checks and medication administration. A MAARC report, dated April 22, 2022, filed by the licensee, detailed an incident where a female resident kissed R3 and held his hand. R3 did not appear distressed and made comments that all the ladies were his girlfriends. Both parties had cognitive vulnerabilities. R3's records lacked an IAPP. R5 R5's diagnoses included cerebrovascular disease, stage 3 chronic kidney disease and unspecified dementia. R5's service agreement indicated she received medication administration, assistance with bathing and hearing aids. R5's records lacked an IAPP. On June 28, 2022 at 8:51 a.m., the MDH surveyor requested resident IAPPs because there	0 630		

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	32913	A. BUILDING: _____ B. WING _____	06/29/2022

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0 630	Continued From page 12 were none in the resident paper records. DW-A said she did not know about any IAPP's, maybe they were in Eldermark, the electronic medical record (EMR) system they used to use but was now discontinued. DW-A said she could try to get access to the old EMR but would have to call IT support. DW-A said they were transitioning to a new EMR but did not have much in there yet. DW-A was not able to access the requested IAPPs for R2, R3 and R5. A policy titled Individual Abuse Prevention Plan, dated November 1, 2021, read: Inspired Senior Living of Hanover will develop and implement an individual abuse prevention plan for each vulnerable adult. All residents in an assisted living facility are categorically considered vulnerable adults. The plan will contain an individualized review or assessment of the person's susceptibility to abuse by another, including: other vulnerable adults; the person's risk of abusing others; statements of specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. TIME PERIOD TO CORRECT: Seven (7) Days	0 630		
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	0 640		

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0 640	Continued From page 13 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 emeregency 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). Findings include: On June 29, 2022 at 2:35 p.m, the MDH surveyor did not see any 911 emergency posting in the common areas of the 2 floors. Director of Wellnes (DW)-A and unlicensed personnel (ULP)-C could not find a 911 emergency number posted in the open common area. DW-A showed the MDH surveyor a 911 posting in the second floor chart room but it was not visible to the second floor common area because the door was closed and the posting was not placed so it was visible through the window into the room. A policy and procedure titled Emergency Preparedness Plan, undated, instructed staff on how to use 911 but did not include where staff would find 911 instructions posted.	0 640		

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0 640	Continued From page 14 TIME PERIOD TO CORRECT: Twenty-one (21) Days	0 640		
0 650 SS=E	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. (b) Each employee record must be retained for at least three years after a paid employee, volunteer, or contractor ceases to be employed by, provide services at, or be under contract with the facility. If a facility ceases operation, employee records must be maintained for three years after facility operations cease.	0 650		

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0 650	Continued From page 15 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain current records for two of three staff reviewed, director of wellness (DW)-A and unlicensed personnel (ULP)-C with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). Findings include: DW-A DW-A was hired February 22, 2022, as Director of Wellness for the licensee and supervised direct care staff. DW-A also provided direct cares to residents. DW-A's personnel file lacked: - orientation records - training records - infection control training - performance reviews - competency evaluations - job description During an interview on June 29, 2022 at 10:00 a.m., DW-A said the regional director was not present on her first day and she had no in-person orientation or training. DW-A said she went out on her own to meet staff and "orient herself". DW-A said there was no administrator when she started working. DW-A said she started some of her assisted living online training courses recently.	0 650		

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0 650	Continued From page 16 During an interview on June 29, 2022 at 10:00 a.m., DW-A said housin manager (HM)-B does some of the onboarding, gets new staff into the computer system. On June 29, 2022 at 11:16 a.m., DW-A provided the MDH surveyor with her on line training transcript which she printed for the MDH surveyor, it was not part of her file. ULP-C ULP-C was hired and began providing direct cares to residents April 15, 2022. ULP-C's personnel file lacked: - orientation records - training records - infection control training - performance reviews - competency evaluations - job description During an interview on June 29, 2022 at 11:42 a.m., ULP-C said she did not have any "real" orientation, no training schedule, no 30-day review. ULP-C said ULP-F trained her in, she followed her and then worked on her own. A policy titled Orientation of Staff and Supervisors and Content, dated November 1, 2021, indicated all staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements before providing services to residents. Evidence of completion of required orientation must be kept in the employee record of each staff person. A policy titled Competency and Training	0 650		

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0 650	Continued From page 17 Evaluations, dated November 1, 2021, indicated a registered nurse will conduct training and competency evaluations of ULPs; a copy off all education, training and competency testing will be kept in each employee's personnel file. TIME PERIOD TO CORRECT: Twenty-one (21) Days	0 650		
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure documentation of baseline TB screening for one of four employees, unlicensed personnel (ULP)-D with records reviewed.	0 660		

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0 660	Continued From page 18 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). Findings include: ULP-D was hired October 24, 2019 and provided direct cares to residents. ULP-D's records lacked a TB baseline screening. The licensee's TB risk assessment, dated July 30, 2021, listed the licensee TB risk as "low". The risk assessment section titled "Quality Improvement" indicated the TB risk assessment was updated annually. During the change of ownership (CHOW) entrance conference on June 27, 2022, at 10:00 a.m., the housing manager (HM)-B stated they did not have a TB risk assessment and she was unsure of what a TB risk assessment was. During an interview on June 27, 2022 at 3:16 p.m., Director of Wellness (DW)-A said she was not sure why the TB baseline screening was not in ULP-D's chart. A policy titled Tuberculosis Screening dated November 1, 2021, read "Staff whose essential job functions require work within the same air space of home care clients will be screened and tested for tuberculosis prior to the staff being exposed to clients. Baseline (on hire) screening will be completed. New staff will be screened for active signs of TB using the Baseline TB	0 660		

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0 660	Continued From page 19 screening tool; new staff will have an IGRA blood test or two step Mantoux conducted with results documented on the baseline screening tool. Staff should be screened for signs and symptoms on an annual basis. TIME PERIOD TO CORRECT: Twenty-one (21) Days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule.	0 680		

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0 680	Continued From page 20 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to implement an Emergency Preparedness Plan (EPP) that contained all the required components listed in Appendix Z. The licensee failed to prominently post the EPP. This had the potential to affect all residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). Findings include: The licensee held an Assisted Living with Dementia License, effective date August 1, 2021 through July 31, 2022 with a resident capacity of 26. During the change of ownership (CHOW) licensee tour at 10:50 a.m., the MDH surveyor did not observe an EPP posted prominently on either of the two floors of the licensee. During an interview on June 27, 2022, at 3:40 p.m., the housing manager (HM)-B said she would check that the new ownership version of the EPP was complete. HM-B said she was fairly new to the job and still learning the process. The MDH surveyor received two versions of EPPs: a 7 page undated document titled Emergency Preparedness Plan, with the former owner's name; and a 13 page document dated November	0 680		

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0 680	Continued From page 21 1, 2021, titled Emergency Preparedness, with the new owner's name. HM-B said the November 1, 2021 EPP was complete. The licensee June 2021 EPP lacked information on: -Develop and maintain EP program no evidence who maintains the EPP no evidence of how risk assessment was done no emerging infectious diseases no evidence on re-establishing utilities - Maintain and annual updates no hazard risk assessment with plan - EPP patient population no information on communication, transportation, supervision and medical needs no details of staff assuming specific roles no written authorization of who assumes authority if administrator absent - Process for collaboration - Development of EPP policies and procedures no evidence a risk assessment was used to develop policies no annual review - Subsistence needs for staff and residents no information on pharmaceutical or medical supplies no information on sewage, alternate energy sources - Tracking staff and patients - Policies/procedures for evacuation no information on staff roles, tracking process - Policies and procedures for sheltering - Policies and procedures for medical documents - Policies and procedures for volunteers - Arrangements with other facilities - Roles under a waiver - Development of a communication plan - Names and contact information	0 680		

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0 680	Continued From page 22 - Emergency officials contact information - Primary/alternate means of communication - Methods of sharing information - Sharing information on occupancy needs no information - LTC family notifications no information - Emergency prep training and testing - Emergency prep training program - Emergency prep testing requirements - Integrated health systems The Emergency Preparedness Plan- Appendix Z policy, dated November 1, 2021, indicated the key elements of the plan include: risk assessment, policies and procedures, a communication plan and staff training and exercises/drills. TIME PERIOD TO CORRECT: Twenty-one (21) Days	0 680		
0 720 SS=F	144G.43 Subd. 2 Access to records The facility must ensure that the appropriate records are readily available to employees and contractors authorized to access the records. Resident records must be maintained in a manner that allows for timely access, printing, or transmission of the records. The records must be made readily available to the commissioner upon request. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the MDH surveyor had access to records in a timely manner. The licensee was unable to produce electronic	0 720		

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0 720	Continued From page 23 records for three of three residents (R2, R3 and R5) reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). Findings include: During the change of ownership (CHOW) entrance conference on June 27, 2022, at 10:00 a.m., the Director of Wellness (DW)-A said they were transitioning from paper charts to an electronic medical record (EMR) system. The new EMR was different from the previous EMR the former owners used. They did not have all their information entered into the new EMR and were learning much of it on their own. During an inerview on June 27, 2022 at 3:40 p.m., housing manager (HM)-B said she was fairly new, started in May, and was still learning the job. HM-B said DW-A would know about resident individual abuse prevention plans (IAPPs) and assessments and should ask her about those records. During an interview on June 28, 2022 at 8:51 a.m., DW-A said she did not know about any resident IAPPs, assessments, medication management plans and treatment plans entered into the new EMR. DW-A stated she did not have access to the old EMR and former ownership did not leave much information behind.	0 720		

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0 720	Continued From page 24 During an interview on June 28, 2022 at 8:51 a.m., HM-B said they have a staff person training them on the new EMR process. During an interview on June 29, 2022, at 10:00 a.m., DW-A said the old EMR was pulled on June 1, 2022 and she was working on getting resident records moved to the new EMR. Resident facesheets were logged in, but not all assessments. The new EMR and the pharmacy system were not currently compatible; DW-A said the medication records would not be entered for some time. DW-A said she and HM-B do not get much IT support from management. A policy titled Assisted Living Director, dated November 1, 2021, indicated the licensed or permitted assisted living director on record is responsible for the ALF and all operations within the setting. TIME PERIOD TO CORRECT: Twenty-one (21) Days	0 720		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to maintain the facility's	0 800		

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0 800	Continued From page 25 physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all residents). The findings include: On June 28, 2022, from approximately 10:20 a.m. to 1:30 p.m., survey staff toured the facility with the housing manager (HM)-B. During the facility tour, survey staff observed the following: 1. Bathroom fans in every occupied room that were surveyed were covered in dust and lint. 2. Apartment 106 had water damage on the ceiling. HM-B was unaware of the damage and repairs were not on a maintenance plan or schedule. 3. Multiple operable windows were not equipped with window stops. Operable windows without window opening control devices could lead to elopement from the first floor or fall risk from the second floor. 4. The sprinkler room had storage in front of electrical panels. Three-foot clear floor space should be maintained in front of electrical panels at all times.	0 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32913	A. BUILDING: _____ B. WING _____	06/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INSPIRED SENIOR LIVING OF HANOVER	10875 SETTLERS LANE HANOVER, MN 55341

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0 800	Continued From page 26 5. Rubber door stops were being used at all apartment doors. Doors were rated and equipped with closers. Rubber door stops inhibit the life safety function of the doors. 6. Licensee could not find a record of generator maintenance. HM-B verbally confirmed survey staff observations during the facility tour. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be	0 810		

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	32913	A. BUILDING: _____ B. WING _____	06/29/2022

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0 810	Continued From page 27 readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide the required fire safety training and evacuation plans for residents and staff. This has the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all residents). The findings include: During interview on June 28, 2022, at 1:30 p.m., the house manager (HM)-B stated they had not done any fire safety training for staff or residents, nor had they completed any evacuation drills. Review of the fire safety policy showed the	0 810		

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	32913	A. BUILDING: _____ B. WING _____	06/29/2022

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0 810	Continued From page 28 following: 1. No evacuation plan or documentation on specific procedures for the residents including procedures for their movements, and relocation during a fire or similar, and no written instructions for addressing any unique situation during an evacuation, especially for residents who are wheelchair-bound and need assistance during an evacuation. The policy was the basic policy from a third-party provider and had not been edited or updated to fit the facility. 2. No record of required employee evacuation drills. 3. No schedule or records on the training of employees on fire safety and evacuation; on proper actions to take in the event of a fire or emergency for the safety of residents including movement, evacuation, or relocation. 4. No schedule or records on the training of residents who are capable of assisting in their evacuation; on proper actions to take in the event of a fire or emergency for their safety including movement, evacuation, or relocation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01320 SS=D	144G.60 Subd. 4 (a) Unlicensed personnel (a) Unlicensed personnel providing assisted living services must have: (1) successfully completed a training and competency evaluation appropriate to the	01320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32913	A. BUILDING: _____ B. WING _____	06/29/2022

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01320	Continued From page 29 services provided by the facility and the topics listed in section 144G.61, subdivision 2, paragraph (a); or (2) demonstrated competency by satisfactorily completing a written or oral test on the tasks the unlicensed personnel will perform and on the topics listed in section 144G.61, subdivision 2, paragraph (a); and successfully demonstrated competency on topics in section 144G.61, subdivision 2, paragraph (a), clauses (5), (7), and (8), by a practical skills test. Unlicensed personnel who only provide assisted living services listed in section 144G.08, subdivision 9, clauses (1) to (5), shall not perform delegated nursing or therapy tasks. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure one of one unlicensed personnel (ULP)-C, successfully completed a training and competency evaluation appropriate to the services provided by the licensee and the topics listed in section 144G.61. This had the potential to affect all 21 residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at 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: ULP-C was hired and began providing direct cares to residents April 15, 2022. ULP-C's	01320		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INSPIRED SENIOR LIVING OF HANOVER	10875 SETTLERS LANE HANOVER, MN 55341

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01320	Continued From page 30 personnel file lacked training and competency evaluation documentation. During an interview on June 29, 2022 at 10:00 a.m., director of wellness (DW)-A said housing manager (HM)-B does some of the onboarding, gets new staff into the computer system and DW-A trains them as she can. She stated she needs to work on the training and hopes the online training modules will help. During an interview on June 29, 2022 at 11:42 a.m., ULP-C said she did not have any "real" orientation, no training schedule, no 30-day review. ULP-C said ULP-F trained her in, she followed her and then worked on her own. During an interview on June 29, 2022 at 2:25 p.m., ULP-F said she had worked at the licensee for five years and did orient new ULPs. ULP-F said it was an informal orientation, no forms, no outlines. ULP-F said she just shows new staff how she works and by 30 days almost everyone catches on. A policy titled Staffing Requirements Licensed Nurse and ULP, dated November 1, 2021, indicated ULPs must successfully complete taining and competency evaluation or demonstrate competency by satisfactorily completing a written or oral test on the tasks ULPs will perform. TIME PERIOD TO CORRECT: Seven (7) Days	01320		
01460 SS=E	144G.63 Subdivision 1 Orientation of staff and supervisors All staff providing and supervising direct services	01460		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32913	A. BUILDING: _____ B. WING _____	06/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01460	Continued From page 31 must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. The orientation may be incorporated into the training required under subdivision 5. The orientation need only be completed once for each staff person and is not transferable to another facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure staff who provided and supervised direct services completed orientation to assisted living facility licensing requirements and regulations before providing services to residents for two of three staff, director of wellness (DW)-A and unlicensed personnel (ULP)-C reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). Findings include: DW-A DW-A was hired February 22, 2022, as Director of Wellness for the licensee and supervised direct care staff. DW-A also provided direct cares to residents. DW-A's personnel file lacked orientation and training records in accordance with 144G statutes.	01460		

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	32913	A. BUILDING: _____ B. WING _____	06/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INSPIRED SENIOR LIVING OF HANOVER	10875 SETTLERS LANE HANOVER, MN 55341

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01460	Continued From page 32 During an interview on June 29, 2022 at 10:00 a.m., DW-A said the regional director was not present on her first day and she had no in-person orientation or training. DW-A said she went out on her own to meet staff and "orient herself". DW-A said there was no administrator when she started working. DW-A said she started some of her assisted living online training courses recently. On June 29, 2022, at 11:16 a.m.,DW-A provided the MDH surveyor with her online training transcript. DW-A's transcript indicated on May 30, 2022 she successfully completed: - Fire Safety: The Basics .50 hour - MN Res Rights and MAARC .50 hour - About Hearing Impairment .50 hour DW-A said she was working on completing other online training as she had time, but worked 10 to 12 hour days, 6 days a week. ULP-C ULP-C was hired and began providing direct cares to residents April 15, 2022. ULP-C's personnel file lacked orientation and training documentation in accordance with 144G statutes. During an interview on June 29, 2022, at 10:00 a.m., DW-A said HM-B does some of the onboarding, gets new staff into the computer system and DW-A trains them as she can. She stated she needs to work on the training and hopes the online training modules will help. During an interview on June 29, 2022 at 11:42 a.m., ULP-C said she did not have any "real"	01460		

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	32913	A. BUILDING: _____ B. WING _____	06/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INSPIRED SENIOR LIVING OF HANOVER	10875 SETTLERS LANE HANOVER, MN 55341

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01460	Continued From page 33 orientation, no training schedule, no 30-day review. ULP-C said ULP-F trained her in, she followed her and then worked on her own. ULP-C said she recently got access to log in to the online training and works on them at home. A policy titled Orientation of Staff and Supervisors and Content, dated November 1, 2021, indicated all staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements before providing services to residents. TIME PERIOD TO CORRECT: Twenty-one (21) Days	01460		
01480 SS=E	144G.63 Subd. 3 Orientation to resident Staff providing assisted living services must be oriented specifically to each individual resident and the services to be provided. This orientation may be provided in person, orally, in writing, or electronically. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure staff providing assisted living services must be oriented specifically to each individual resident and the services to be provided for two of three staff, director of wellness (DW)-A and unlicensed personnel (ULP)-C. This orientation may be provided in person, orally, in writing, or electronically. 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	01480		

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	32913	A. BUILDING: _____ B. WING _____	06/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INSPIRED SENIOR LIVING OF HANOVER	10875 SETTLERS LANE HANOVER, MN 55341

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01480	Continued From page 34	01480		

resident's health or safety), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).

Findings include:

DW-A

DW-A was hired February 22, 2022, as Director of Wellness for the licensee and supervised direct care staff. DW-A also provided direct cares to residents. DW-A's personnel file lacked orientation and training records in accordance with 144G statutes.

DW-A's personnel file lacked documentation that she was oriented to each resident and how she was oriented.

During an interview on June 29, 2022, at 10:00 a.m., DW-A said the regional director was not present on her first day and she had no in-person orientation or training. DW-A said she went out on her own to meet staff and "orient herself". DW-A said there was no administrator when she started working.

ULP-C

ULP-C was hired and began providing direct cares to residents April 15, 2022. ULP-C's personnel file lacked orientation and training documentation in accordance with 144G statutes.

ULP-C's personnel file lacked documentation that she was oriented to each resident and how she

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	32913	A. BUILDING: _____ B. WING _____	06/29/2022

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01480	Continued From page 35 was oriented. During an interview on June 29, 2022, at 11:42 a.m., ULP-C said she did not have any "real" orientation, no training schedule, no 30-day review. ULP-C said ULP-F trained her in, she followed her and then worked on her own. During an interview on June 29, 2022, at 2:25 p.m., ULP-F said she had worked at the licensee for five years and did orient new ULPs. ULP-F said it was an informal orientation, no forms, no outlines. ULP-F said she just shows new staff how she works and by 30 days almost everyone catches on. A policy titled Orientation of Staff and Supervisors and Content, dated November 1, 2021, indicated all staff providing and supervising direct services must be oriented specifically to each each individual resident and the services to be provided. TIME PERIOD TO CORRECT: Twenty-one (21) Days	01480		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an	01620		

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	32913	A. BUILDING: _____ B. WING _____	06/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INSPIRED SENIOR LIVING OF HANOVER	10875 SETTLERS LANE HANOVER, MN 55341

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01620	Continued From page 36 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 ongoing resident reassessment and monitoring was conducted as needed based on changes in the needs of one of three residents (R3) reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at 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: R3's diagnoses included unspecified dementia and cardiac arrhythmia. R3's service agreement, dated November 11, 2021, indicated R3 received wellness checks and medication administration.	01620		

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	32913	A. BUILDING: _____ B. WING _____	06/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INSPIRED SENIOR LIVING OF HANOVER	10875 SETTLERS LANE HANOVER, MN 55341

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01620	Continued From page 37 R3's record lacked reassessments and an individual abuse prevention plan (IAPP). During the change of ownership (CHOW) entrance conference on June 27, 2022, at 10:00 a.m., the Director of Wellness (DW)-A said they were transitioning from paper charts to an electronic medical record (EMR) system. The new EMR was different from the previous EMR the former owners used. They did not have all their information entered into the new EMR and were learning much of it on their own. During an interview on June 27, 2022, at 3:40 p.m., housing manager (HM)-B said she was fairly new, started in May, and was still learning the job. HM-B said DW-A would know about resident IAPPs and assessments and should ask her about those records. During an interview on June 28, 2022, at 8:51 a.m., DW-A said she did not know about any resident IAPPs, assessments, medication management plans and treatment plans entered into the new EMR. DW-A stated she did not have access to the old EMR and former ownership did not leave much information behind. During an interview on June 29, 2022, at 3:00 p.m., R3 said he has lived at the licensee for one year. His wife lived with him and she died a few weeks ago. R3 said after his wife's death another female resident follows him around and he does not like it, he is still grieving. R3 stated he told HM-B and she is aware of the issue. A policy titled Assessments, Reviews and Monitoring, dated November 1, 2021, read: Ongoing resident reassessment and monitoring	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32913	A. BUILDING: _____ B. WING _____	06/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01620	Continued From page 38 must be conducted as needed based on changes in the needs of the resident. TIME PERIOD TO CORRECT: Seven (7) Days	01620		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure unlicensed personnel (ULP)-E accurately documented when a medication was administered to two of three residents (R2 and R5) reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at 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).	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32913	A. BUILDING: _____ B. WING _____	06/29/2022

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INSPIRED SENIOR LIVING OF HANOVER	10875 SETTLERS LANE HANOVER, MN 55341

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01760	Continued From page 39 Findings include: R2's diagnoses include unspecified convulsions, atrial fibrillation and difficulty walking. R2's service agreement, dated November 23, 2021, indicated R2 received assistance with activities of daily living (ADLs), medication administration, and cueing for social activities. R5's diagnoses included cerebrovascular disease, stage 3 chronic kidney disease and unspecified dementia. R5's service agreement indicated she received medication administration, assistance with bathing and hearing aids. R5 had a prescription for caridopa 25 mg - 100 mg 2 tabs po at 10:00 am. On June 28, 2022, at 10:00 a.m. ULP-E prepared R5's caridopa and initialed R5's medication administration record (MAR) before offering R5 the medication. ULP-E then went to R5's room and gave R5 the pills and some water. ULP-E acknowledged she initialed the medication as "given" before she approached R5 and said she was sorry. ULP-E said if R5 had refused the medication she would circle her initials and document why the medication was not given. R2 had a prescription for acetaminophen 500 mg ES tab, take 2 tabs (1,000 mg) by mouth three times daily for leg pain. On June 28, 2022 at 12:00 p.m., ULP-E prepared R2's acetaminophen and initialed R2's MAR prior to giving R2 her medication.	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32913	A. BUILDING: _____ B. WING _____	06/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INSPIRED SENIOR LIVING OF HANOVER	10875 SETTLERS LANE HANOVER, MN 55341

(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
01760	Continued From page 40 During an interview on June 29, 2022 at 10:00 a.m., DW-A said staff should initial the resident MAR after administering a medication. A policy titled Medication and Treatment Record Documentation and Refusal, dated November 1, 2021, read: documentation of medication/treatment/therapy administration will be completed by the person who performed the task immediately after the medication assistance/administration is completed. TIME PERIOD TO CORRECT: Seven (7) Days	01760		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to conduct a hazard vulnerability or safety risk assessment on or around the facility property. This had the potential to directly affect all residents, staff, and visitors.	02040		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32913	A. BUILDING: _____ B. WING _____	06/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INSPIRED SENIOR LIVING OF HANOVER	10875 SETTLERS LANE HANOVER, MN 55341

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02040	Continued From page 41 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 residents). The findings include: Survey staff requested a facility hazard vulnerability or safety risk assessment documentation, but the licensee did not provide the requested documentation. During interview on June 28, 2022, at 1:35 p.m., the house manager (HM)-B stated she thought they had a completed hazard vulnerability assessment, but did not know where it was. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		

Minnesota Department of Health

625 North Robert Street
Saint Paul, MN
651-201-5000

Type: Full
Date: *06/28/22*
Time: 13:00:00
Report: 8087221159

Food and Beverage Establishment Inspection Report

Location:
Bridgewater At Hanover Llc
10875 Settlers Lane
Hanover, MN55341
Hennepin County, 27

Establishment Info:
ID #: 0039056
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7634630708
ID #:

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

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

Wash Temperature Gauge: = -- at 157 Degrees Fahrenheit
Location: DISH MACHINE - 2ND FLOOR
Violation Issued: No

Rinse Temperature Gauge: = -- at 175 Degrees Fahrenheit
Location: DISH MACHINE - 2ND FLOOR
Violation Issued: No

Max Utensil Surface Temp: = -- at 169 Degrees Fahrenheit
Location: DISH MACHINE - 2ND FLOOR
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Ambient Air
Temperature: -1 Degrees Fahrenheit - Location: STAND-UP FREEZER - 1ST FLOOR
Violation Issued: No

Process/Item: Ambient Air
Temperature: 34 Degrees Fahrenheit - Location: STAND-UP COOLER - 1ST FLOOR
Violation Issued: No

Process/Item: Cold Holding: EGGS
Temperature: 35 Degrees Fahrenheit - Location: STAND-UP COOLER - 1ST FLOOR
Violation Issued: No

Process/Item: Cold Holding: MILK
Temperature: 36 Degrees Fahrenheit - Location: STAND-UP COOLER - 1ST FLOOR
Violation Issued: No

Process/Item: Cold Holding: MAC & CHEESE
Temperature: 34 Degrees Fahrenheit - Location: STAND-UP COOLER - 1ST FLOOR
Violation Issued: No

Process/Item: Cold Holding: CUT LFY GRN
Temperature: 36 Degrees Fahrenheit - Location: STAND-UP COOLER - 1ST FLOOR
Violation Issued: No

Process/Item: Cold Holding: PASTA SALAD
Temperature: 35 Degrees Fahrenheit - Location: STAND-UP COOLER - 1ST FLOOR
Violation Issued: No

Process/Item: Ambient Air
Temperature: 34 Degrees Fahrenheit - Location: STAND-UP COOLER - 2ND FLOOR
Violation Issued: No

Process/Item: Cold Holding: COTTAGE CHZ
Temperature: 35 Degrees Fahrenheit - Location: STAND-UP COOLER - 2ND FLOOR
Violation Issued: No

Process/Item: Cold Holding: YOGURT
Temperature: 35 Degrees Fahrenheit - Location: STAND-UP COOLER - 2ND FLOOR
Violation Issued: No

Process/Item: Cold Holding: MILK
Temperature: 35 Degrees Fahrenheit - Location: STAND-UP COOLER - 2ND FLOOR
Violation Issued: No

Process/Item: Cold Holding: SOUR CREAM
Temperature: 35 Degrees Fahrenheit - Location: STAND-UP COOLER - 2ND FLOOR
Violation Issued: No

Process/Item: Cold Holding: CHEESE
Temperature: 36 Degrees Fahrenheit - Location: STAND-UP COOLER - 2ND FLOOR
Violation Issued: No

Process/Item: Cold Holding: SHELL EGG
Temperature: 36 Degrees Fahrenheit - Location: STAND-UP COOLER - 2ND FLOOR
Violation Issued: No

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

THIS WAS AN ANNOUNCED AND SCHEDULED FULL INSPECTION.

INSPECTION CONDUCTED IN THE PRESENCE OF RAPID RESPONSE EVALUATOR LISSA LIN.

HOT WATER TEMPERATURE AT THE KITCHEN SINK REACHED 120 DEGREES.

INSPECTION REPORT EMAILED TO LISSA LIN (Rapid Response Evaluator).

- REPAIR OR REMOVE 1ST FLOOR DISH MACHINE
- FOOD DEBRIS OBSERVED AT BOTTOM OF TOASTER

- NO FULL TIME EMPLOYEE HAS CERTIFIED FOOD PROTECTION MANAGER CERTIFICATE

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 8087221159 of 06/28/22.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/ /_____

Inspection report reviewed with person in charge and emailed.

Signed:_____
VIOLA PASS
MANAGER

Signed:_____
John Boettcher
Public Health Sanitarian 3
St. Paul, MN / Freeman
651-201-5076
john.boettcher@state.mn.us