



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

February 17, 2023

Licensee
The Harbors Senior Living of Fridley
5300 4th Street Northeast
Fridley, MN 55421

RE: Project Number(s) SL33169015

Dear Licensee:

The Minnesota Department of Health completed an evaluation on January 19, 2023, 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.

LICENSING ORDERS

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:

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - \$500.00

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

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 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

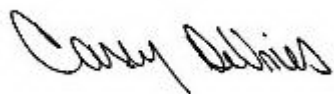
REQUESTING A HEARING

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 Department of Health 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 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,



Casey DeVries, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: casey.devries@state.mn.us
Phone: 651-201-5917 Fax: 651-215-6894

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33169	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/19/2023
NAME OF PROVIDER OR SUPPLIER THE HARBORS SENIOR LIVING FRID		STREET ADDRESS, CITY, STATE, ZIP CODE 5300 4TH STREET NE FRIDLEY, MN 55421		
(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: SL33169015-0 On January 17, 2023, through January 19, 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 39 residents, all of whom received services under the Assisted Living with Dementia Care license.	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 License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33169	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/19/2023
NAME OF PROVIDER OR SUPPLIER THE HARBORS SENIOR LIVING FRID		STREET ADDRESS, CITY, STATE, ZIP CODE 5300 4TH STREET NE FRIDLEY, MN 55421		
(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
0 480	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared according to the Minnesota Food Code. This 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, 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 January 17, 2023.	0 480		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33169	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/19/2023
NAME OF PROVIDER OR SUPPLIER THE HARBORS SENIOR LIVING FRID		STREET ADDRESS, CITY, STATE, ZIP CODE 5300 4TH STREET NE FRIDLEY, MN 55421		
(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
0 480	Continued From page 2 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b) The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an effective infection control program to comply with accepted health care, medical, and nursing standards for infection control and current recommendations for hand hygiene. This had the potential to affect all of the licensee's residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents).	0 510		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33169	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/19/2023
NAME OF PROVIDER OR SUPPLIER THE HARBORS SENIOR LIVING FRID		STREET ADDRESS, CITY, STATE, ZIP CODE 5300 4TH STREET NE FRIDLEY, MN 55421		
(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
0 510	Continued From page 3 The findings include: On January 18, 2023, at 7:39 a.m., the evaluator observed unlicensed personnel (ULP)-J remove a soiled incontinence product, place it on the floor, then proceed to provide peri (perineal) care on R8. After peri-care, ULP-J placed the incontinence product in the garbage can. On January 18, 2023, from 8:19 a.m. to 8:40 a.m., the evaluator observed ULP-J apply gloves without performing hand hygiene. ULP-J then removed R4's soiled incontinence product, placed it on the floor, provided peri-care, transferred R4 from bed to wheelchair, changed the soiled bed linens, assisted R4 with applying oxygen tubing and starting oxygen concentrator, dressed, groomed, and transferred R4 from wheelchair to bed. ULP-J then removed gloves, collected the soiled incontinence product and garbage from R4's room and placed in the trash receptacle before performing hand hygiene. On January 18, 2023, at 8:02 a.m., the evaluator observed ULP-G apply gloves and assist R6 with incontinent pull up removal. Without removing soiled gloves and performing hand hygiene, ULP-G brought nystatin powder 100,000 units (U) / milliliter (ml) from the living room table to the bathroom, provided peri-care to R6 and removed gloves. Without performing hand hygiene, ULP-G applied gloves, applied nystatin powder 100,000 u/ml to R6's groin and abdominal folds, assisted with application of incontinent brief and incontinent pull up to R6, removed gloves, and performed hand hygiene. On January 18, 2023, at 8:24 a.m., the evaluator observed ULP-I apply gloves then empty R2's catheter bag while ULP-H applied gloves, lowered	0 510		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33169	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/19/2023
NAME OF PROVIDER OR SUPPLIER THE HARBORS SENIOR LIVING FRID		STREET ADDRESS, CITY, STATE, ZIP CODE 5300 4TH STREET NE FRIDLEY, MN 55421		
(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
0 510	Continued From page 4 the front of R2's brief, and provided catheter care. ULP-I applied cream to the perineal area of R2 then assisted ULP-H to remove R2's incontinent brief. ULP-I and ULP-H removed gloves. Without performing hand hygiene, ULP-I and ULP-H applied new gloves. ULP-I assisted R2 with lower body dressing, then ULP-I and ULP-H transferred R2 into wheelchair and completed R2's oral cares and upper body dressing. ULP-I and ULP-H removed gloves after completion of upper body dressing and performed hand hygiene. On January 18, 2023, at 11:19 a.m., ULP-I stated they were trained to perform hand hygiene when entering a room, after tasks were performed, and after glove removal. The evaluator inquired why ULP-I did not perform hand hygiene after glove removal. ULP-I stated, "not sure why I did not do it." On January 18, 2023, at 2:03 p.m., registered nurse (RN)-C stated staff were trained on glove application/removal and hand hygiene by direct supervision and received a competency on the skills. In addition, RN-C stated staff were trained to wash their hands after assisting with toileting, between residents, assisting with feeding, and anytime they provided cares to a resident. The Center of Disease Control (CDC) Morbidity and Mortality Weekly Report (MMWR) Guidelines for Hand Hygiene in Health-Care Settings dated October 25, 2022, recommend hand hygiene to be completed before direct contact with patient [residents], moving from a contaminated-body site to a clean-body site during care, and after removing gloves. The licensee's Standard Precautions policy dated	0 510		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33169	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 01/19/2023
NAME OF PROVIDER OR SUPPLIER THE HARBORS SENIOR LIVING FRID			STREET ADDRESS, CITY, STATE, ZIP CODE 5300 4TH STREET NE FRIDLEY, MN 55421		
(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	
0 510	Continued From page 5 August 1, 2021, indicated the Minnesota Department of Health (MDH) and/or CDC recommendations would be followed for standard precautions. The licensee's Gloves policy dated August 1, 2021, indicated hand hygiene would be completed after glove removal. The licensee's Hand Washing policy dated August 1, 2021, indicated hand hygiene would be completed: - before, during, and after preparing food; - before eating food; - before and after caring for someone who is sick; - before and after treating a cut or wound; - after using the toilet; - after changing diapers or cleaning up after someone who has used the toilet; - after blowing your nose, coughing, or sneezing; - after touching an animal or animal waste; - after handling pet food or pet treats; and - after touching garbage. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510			
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity	0 660			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33169	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/19/2023
NAME OF PROVIDER OR SUPPLIER THE HARBORS SENIOR LIVING FRID		STREET ADDRESS, CITY, STATE, ZIP CODE 5300 4TH STREET NE FRIDLEY, MN 55421		
(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
0 660	Continued From page 6 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 maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), which included a two-step tuberculin skin test (TST) or other evidence of TB screening such as a blood test, for two of three (unlicensed personnel (ULP)-D and ULP-E) and a completed health history and symptom screening for three of three employees (registered nurse (RN)-C, ULP-D, ULP-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The facility TB risk assessment was completed September 1, 2022, and indicated the facility was at a low risk for TB transmission.	0 660		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33169	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/19/2023
NAME OF PROVIDER OR SUPPLIER THE HARBORS SENIOR LIVING FRID		STREET ADDRESS, CITY, STATE, ZIP CODE 5300 4TH STREET NE FRIDLEY, MN 55421		
(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
0 660	Continued From page 7 RN-C RN-C had a hire date of August 8, 2022, to provide supervision and oversight to unlicensed personnel and provide direct services residents. RN-C employee record included a TB history and symptom screen completed on July 24, 2018, from different licensee. RN-C's record lacked a TB history and symptom screen completed after hire. ULP-D ULP-D was hired December 22, 2022, and provided direct care services to licensee residents. ULP-D's record lacked evidence a TB history and symptom screening and baseline screening was completed. ULP-E ULP-E was hired November 21, 2022, and provided direct care services to licensee residents. ULP-E's record lacked evidence a TB history and symptom screening and baseline screening was completed. On January 18, 2023, at 2:02 p.m., RN-C stated staff completed a two-step Mantoux and TB history and symptom screen upon hire. In addition, RN-C stated they did not complete a TB history and symptom screen for the licensee, however, did at a sister facility. On January 19, 2023, at 11:25 a.m., licensed assisted living director (LALD)-A stated they had not made it a requirement to complete TB screenings upon hire. LALD-A stated a previous nurse had told her it was not required. However, they do complete a history and symptom screening annually.	0 660		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33169	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/19/2023
NAME OF PROVIDER OR SUPPLIER THE HARBORS SENIOR LIVING FRID		STREET ADDRESS, CITY, STATE, ZIP CODE 5300 4TH STREET NE FRIDLEY, MN 55421		
(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
0 660	Continued From page 8 The licensee's Tuberculosis Screening policy dated August 1, 2021, indicated 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. Screening will be conducted as follows: 1. New staff will be screened for active signs of TB using the Baseline TB Screening Tool for HCW's. 2. New staff will have an IGRA blood test or a two-step Mantoux conducted with results documented on the Baseline Screening Tool for HCWs. 3. No staff will be permitted to begin work where the work involves sharing the air space with residents until the negative results of the first Mantoux are read and documented or a negative IGRA blood test result is received and documented. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor;	0 680		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33169	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/19/2023
NAME OF PROVIDER OR SUPPLIER THE HARBORS SENIOR LIVING FRID		STREET ADDRESS, CITY, STATE, ZIP CODE 5300 4TH STREET NE FRIDLEY, MN 55421		
(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
0 680	Continued From page 9 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. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a written emergency preparedness plan with all the required content. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 January 18, 2023, at 2:14 p.m., registered nurse (RN)-C stated they were unaware of the requirements of Appendix Z and the licensed assisted living director was responsible for the emergency preparedness plan. On January 19, 2023, at 11:25 a.m., licensed	0 680		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33169	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/19/2023
NAME OF PROVIDER OR SUPPLIER THE HARBORS SENIOR LIVING FRID		STREET ADDRESS, CITY, STATE, ZIP CODE 5300 4TH STREET NE FRIDLEY, MN 55421		
(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
0 680	Continued From page 10 assisted living director (LALD)-A stated the company attorneys developed the emergency plan and she was not aware of the required content of appendix Z. The licensee's Emergency Preparedness Plan - appendix Z Compliance policy dated August 1, 2021, indicated it is the intent that [the facility] has in place an effective and compliant Emergency Preparedness Plan. The intent is the plan will be aligned with the Centers for Medicare and Medicaid Services State Operation Manual Appendix Z: "State Operations Manual Appendix Z-Emergency Preparedness for All Provides and Certified Supplier Types: Interpretive Guidance." No additional information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by:	0 790		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33169	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/19/2023
NAME OF PROVIDER OR SUPPLIER THE HARBORS SENIOR LIVING FRID		STREET ADDRESS, CITY, STATE, ZIP CODE 5300 4TH STREET NE FRIDLEY, MN 55421		
(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
0 790	Continued From page 11 Based on observation and interview, the licensee failed to maintain the portable fire extinguishers. This deficient condition had the ability to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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). Findings include: On January 17, 2023, between 12:20 p.m. and 2:15 p.m., survey staff toured the facility with the care provider (CP)-F. During the facility tour, survey staff observed portable fire extinguishers with service tags dated August 2021. This deficient condition was verified by CP-F accompanying on the facility tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		
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.	0 800		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33169	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/19/2023
NAME OF PROVIDER OR SUPPLIER THE HARBORS SENIOR LIVING FRID		STREET ADDRESS, CITY, STATE, ZIP CODE 5300 4TH STREET NE FRIDLEY, MN 55421		
(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
0 800	Continued From page 12 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 with regard to the health, safety, comfort, and well-being of the residents. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a 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 January 17, 2023, between 12:20 p.m. and 2:15 p.m., survey staff toured the facility with the care provider (CP)-F. During the facility tour, survey staff observed the following: 1. Door locks were not working properly in the following locations: a. first-floor sprinkler room b. first-floor closet c. second-floor laundry room d. third-floor medication room e. third-floor laundry room 2. Outside a marked exit door, the path leading to the public way was covered with snow and had not been maintained. 3. The hallway was used for storage on the main floor which obstructed the path to a marked exit. 4. The service tags for the emergency exit lights	0 800		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33169	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/19/2023
NAME OF PROVIDER OR SUPPLIER THE HARBORS SENIOR LIVING FRID		STREET ADDRESS, CITY, STATE, ZIP CODE 5300 4TH STREET NE FRIDLEY, MN 55421		
(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
0 800	Continued From page 13 and the kitchen ANSUL system were dated August 2021. 5. The electromagnetic door holder was broken on the activity office door on the main floor. 6. Several wall tiles were missing in the bathroom for resident room 203. These deficient conditions were verified by CP-F accompanying on the facility tour. TIME PERIOD FOR CORRECTION: Two (2) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to	0 810		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33169	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/19/2023
NAME OF PROVIDER OR SUPPLIER THE HARBORS SENIOR LIVING FRID		STREET ADDRESS, CITY, STATE, ZIP CODE 5300 4TH STREET NE FRIDLEY, MN 55421		
(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
0 810	Continued From page 14 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 record review and interview, the licensee failed to provide the required employee and resident training on fire safety and evacuation and failed to document the required employee evacuation drills. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a 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 January 17, 2023, at approximately 2:15 p.m., records were provided for review. Records were reviewed by survey staff on January 17, 2023, between 2:15 p.m. and 2:50 p.m. Record review of available documentation indicated that the licensee did not provide employee training on the fire safety and evacuation plans upon hire and at least twice per year thereafter as required by statute. Records	0 810		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33169	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/19/2023
NAME OF PROVIDER OR SUPPLIER THE HARBORS SENIOR LIVING FRID		STREET ADDRESS, CITY, STATE, ZIP CODE 5300 4TH STREET NE FRIDLEY, MN 55421		
(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
0 810	Continued From page 15 were requested by survey staff but not provided to support that the required employee training frequency had been met. Record review of the available documentation indicated that the licensee did not provide annual training to residents who can assist in their own evacuation on the proper actions to take in the event of a fire to include movement, evacuation, or relocation as required by statute. Documentation was requested by survey staff but not provided to support that annual resident training had been completed. The training frequency specified in the policies for resident training was at orientation. Record review of the available documentation for evacuation drills indicated that evacuation drills for employees had not been recorded. Evacuation drill schedules for 2022 and 2023 were provided. No evacuation drill logs or records were included to support that the scheduled drills in 2022 had been completed. On January 17, 2023, at approximately 3:00 p.m., during an interview, the LALD-A verified these deficient conditions. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 940 SS=C	144G.50 Subd. 2 (e; 5-7) Contract information (5) a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including: (i) whether the facility is enrolled with the commissioner of human services to provide	0 940		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33169	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/19/2023
NAME OF PROVIDER OR SUPPLIER THE HARBORS SENIOR LIVING FRID		STREET ADDRESS, CITY, STATE, ZIP CODE 5300 4TH STREET NE FRIDLEY, MN 55421		
(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
0 940	Continued From page 16 customized living services under medical assistance waivers; (ii) whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b); (iii) whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided; (iv) whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required; (v) a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent; (vi) a statement that residents may be eligible for assistance with rent through the housing support program; and (vii) a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program; (6) the contact information to obtain long-term care consulting services under section 256B.0911; and (7) the toll-free phone number for the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written assisted living contract with all required content for three of three residents (R1, R2, R4). This practice resulted in a level one violation (a violation that has no potential to cause more than	0 940		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33169	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/19/2023
NAME OF PROVIDER OR SUPPLIER THE HARBORS SENIOR LIVING FRID		STREET ADDRESS, CITY, STATE, ZIP CODE 5300 4TH STREET NE FRIDLEY, MN 55421		
(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
0 940	Continued From page 17 a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: R1, R2 and R4's Resident Agreement lacked the licensee's information on the following content: - whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided; - whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required; - a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent; - a statement that residents may be eligible for assistance with rent through the housing support program; and - a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program. On January 19, 2023, at 1:03 p.m., licensed assisted living director (LALD)-A stated the licensee used the same contract for all residents who resided in the facility. LALD-A stated the licensee allowed two residents with waived services in the building at a time. In addition, LALD-A stated they were unaware of the content required.	0 940		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33169	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/19/2023
NAME OF PROVIDER OR SUPPLIER THE HARBORS SENIOR LIVING FRID		STREET ADDRESS, CITY, STATE, ZIP CODE 5300 4TH STREET NE FRIDLEY, MN 55421		
(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
0 940	Continued From page 18 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 940		
0 950 SS=C	144.50 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 right at any time to add, remove, or change the name and contact information of the designated representative.	0 950		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33169	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/19/2023
NAME OF PROVIDER OR SUPPLIER THE HARBORS SENIOR LIVING FRID		STREET ADDRESS, CITY, STATE, ZIP CODE 5300 4TH STREET NE FRIDLEY, MN 55421		
(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
0 950	Continued From page 19 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to offer the opportunity to identify a designated representative for one of three residents (R2). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: R2 admitted for assisted living services on March 23, 2022. R2's Resident Agreement was signed on March 23, 2022. R2's Resident Agreement lacked the opportunity to designate a representative and the verbatim "right to designate a representative for certain purposes" notice. On January 18, 2023, at approximately 2:00 p.m., licensed assisted living director (LALD)-A verified R2's contract lacked opportunity to designate a representative and the verbatim "right to designate a representative for certain purposes" notice. LALD-A stated she is aware the designated representative needs the verbatim wording and a box to decline a designated representative and has the form, but has not had it signed by R2.	0 950		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33169	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/19/2023
NAME OF PROVIDER OR SUPPLIER THE HARBORS SENIOR LIVING FRID		STREET ADDRESS, CITY, STATE, ZIP CODE 5300 4TH STREET NE FRIDLEY, MN 55421		
(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
0 950	Continued From page 20 On January 19, 2023, at 1:02 p.m., LALD-A stated the licensee used the same contract for all residents who resided in the facility. In addition, LALD-A stated they located the correct paper to meet requirement, however, were unsure why they did not include it in the current contract. The licensee's Designated Representative policy dated August 1, 2021, indicated the licensee would offer residents the opportunity to identify a designated representative in writing. In addition, a signed Designated Representative form must be filled out documenting the residents' choice in designated representative, the form will be kept in the resident record. The policy had the Designated Representative form attached. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 950		
0 970 SS=F	144.50 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: .	0 970		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33169	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/19/2023
NAME OF PROVIDER OR SUPPLIER THE HARBORS SENIOR LIVING FRID		STREET ADDRESS, CITY, STATE, ZIP CODE 5300 4TH STREET NE FRIDLEY, MN 55421		
(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
0 970	Continued From page 21 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 two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: The licensee's Resident Agreement included language which indicated waivers of liability for the following: Page: 7 Personal Property "You agree that Landlord is not responsible for any loss or damage to your personal property due to theft, or damage due to fire, water, tornado or other acts of nature and event beyond Landlord's control. You are strongly encouraged to obtain renter's insurance." Page: 8 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 by wholly or in part by an act or omission of Tenant or Tenant's guests or agents."	0 970		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33169	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/19/2023
NAME OF PROVIDER OR SUPPLIER THE HARBORS SENIOR LIVING FRID		STREET ADDRESS, CITY, STATE, ZIP CODE 5300 4TH STREET NE FRIDLEY, MN 55421		
(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
0 970	Continued From page 22 Page:8-9 Insurance "Landlord will maintain appropriate levels and types of insurance covering the building and its contents. Because Landlord does not maintain insurance covering the contents of tenant's Apartment Units, Tenant is strongly encouraged to carry appropriate levels of liability insurance covering both the contents of the Apartment Unit as well as any injury to Tenant or Tenant's guests occurring within the Apartment Unit (this is usually called "renter's insurance"). Tenant acknowledges and understands that lack of such insurance coverage may result in personal loss to and/or liability of Tenant. If Tenant has a waterbed, Tenant must specifically insure damage that may be caused by the same. Tenant agrees to provide Landlord with a certificate of insurance upon request." "In the event Tenant's property is damaged or destroyed by fire, efforts to extinguish a fire, or other causes that may be covered standard fire and extended coverage insurance, or by other insurance coverage, you hereby waive: (a) all claims against Landlord and its representatives for any such loss or damage; (b) all rights of subrogation of any insurance covering such damage or destruction." Page:8 Liability "Landlord is not held liable to Tenant or Tenant's guest for any injury, death or property damage occurring in the Apartment Unit or on Landlord's premises unless such injury, death or damage of property 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	0 970		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33169	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/19/2023
NAME OF PROVIDER OR SUPPLIER THE HARBORS SENIOR LIVING FRID		STREET ADDRESS, CITY, STATE, ZIP CODE 5300 4TH STREET NE FRIDLEY, MN 55421		
(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
0 970	Continued From page 23 be liable to Tenant for its own negligent acts or those of its employees of agents. Unless caused by one of the aforementioned excepted reasons, 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 Apartment Unit or on Landlord's premises." "Tenant will not be liable to Landlord, or any other person claiming through or under Landlord by right of subrogation or otherwise, for damage to the Apartment Unit or to Landlord's premises from causes or risks normally covered by standard fire and extended coverage insurance, or which are actually covered by any other insurance. The parties to this Agreement shall procure from their insurer a waiver of all rights of subrogation which one insurer under said policies might have as against another, said waiver to be in writing for the express benefit of the other. On January 19, 2023, at 1:07 p.m., licensed assisted living director (LALD)-A stated the licensee used the same contract for all residents who resided in the facility. LALD-A stated they were aware contract contained the information listed above and the licensee would remove the content from the contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent	01060		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33169	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/19/2023
NAME OF PROVIDER OR SUPPLIER THE HARBORS SENIOR LIVING FRID		STREET ADDRESS, CITY, STATE, ZIP CODE 5300 4TH STREET NE FRIDLEY, MN 55421		
(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
01060	Continued From page 24 risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section. This MN Requirement is not met as evidenced by:	01060		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33169	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/19/2023
NAME OF PROVIDER OR SUPPLIER THE HARBORS SENIOR LIVING FRID		STREET ADDRESS, CITY, STATE, ZIP CODE 5300 4TH STREET NE FRIDLEY, MN 55421		
(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
01060	Continued From page 25 Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation to the resident, legal representative, or designated representative for two of two residents (R2, R4) and failed to provide the notification to the Office of Ombudsman for Long-Term Care of the emergency relocation greater than four days for one of two residents (R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: R2 R2's Service Plan dated January 4, 2023, indicated R2 was receiving services to include bathing assistance, dressing, grooming, housekeeping, laundry, toileting, catheter care, and medication administration. R2's progress notes dated December 27, 2022, indicated R2 was bypassing urine, complaining of pain and burning in his bladder, had new onset confusion and was sent to Mercy Hospital for evaluation and was admitted for urinary tract infection and COVID. R2's record lacked a written notice with the required statutory content provided to resident or resident representative of emergency relocation. R4	01060		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33169	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/19/2023
NAME OF PROVIDER OR SUPPLIER THE HARBORS SENIOR LIVING FRID		STREET ADDRESS, CITY, STATE, ZIP CODE 5300 4TH STREET NE FRIDLEY, MN 55421		
(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
01060	Continued From page 26 R4's Service Plan dated January 4, 2023, indicated R4 was receiving services to include bathing assistance, dressing, grooming, housekeeping, laundry, toileting, tube feeding, and medication administration. R4's Hospital discharge summary dated December 28, 2022, indicated R4 had an emergency relocation to Mercy Hospital on December 14, 2022 due to acute hypoxemic respiratory failure (a condition in which a patient's [resident] lungs have difficulty exchanging oxygen and carbon dioxide with the blood) and discharged from hospital back to licensee on December 28, 2022. R2's progress note dated December 30, 2022, indicated resident returned to facility from the hospital. R4's record lacked a written notice with the required statutory content provided to resident, resident representative or to the OOLTC within four days of emergency relocation. On January 18, 2023, at 2:00 p.m., Licensed Assisted Living Director (LALD-A) stated the licensee failed to provide an emergency relocation notice to R2. LALD-A stated the licensee had not provided the notice to any resident who had an emergency relocation as licensee was not aware of the requirement. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
01440 SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs	01440		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33169	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/19/2023
NAME OF PROVIDER OR SUPPLIER THE HARBORS SENIOR LIVING FRID		STREET ADDRESS, CITY, STATE, ZIP CODE 5300 4TH STREET NE FRIDLEY, MN 55421		
(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
01440	Continued From page 27 (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a registered nurse (RN) conducted direct supervision of staff performing a delegated task within 30 days of providing services for one of two employees (unlicensed personnel (ULP)-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all	01440		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33169	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/19/2023
NAME OF PROVIDER OR SUPPLIER THE HARBORS SENIOR LIVING FRID		STREET ADDRESS, CITY, STATE, ZIP CODE 5300 4TH STREET NE FRIDLEY, MN 55421		
(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
01440	Continued From page 28 the residents). The findings include: ULP-E had a hire date of September 21, 2022. ULP-E's employee record lacked documentation of direct supervision of performing a delegated task within 30 days of providing services to verify the work was performed competently and to identify problems and solutions to address issues relating to the staff's ability to provide the services. ULP-E's 30-day staff performance review document dated October 27, 2022, indicated ULP-E was evaluated on performance factors to include customer focus, communication, teamwork and attitude, productivity, safety, and dependability. The evaluation did not include the supervision of any delegated tasks and was signed by licensed practical nurse (LPN)-B. On January 19, 2023, at 1:20 p.m., licensed assisted living director (LALD)-A stated she was not aware a registered nurse must complete the 30-day supervisions of staff and she thought it was okay for the LPN to do so. On January 20, 2023, at 12:56 p.m., LALD-A stated the same 30-day staff performance form was used for all supervision of staff. The licensee's undated Supervision of Unlicensed Personnel policy indicated direct supervision of unlicensed staff providing delegated nursing tasks, delegated treatments or assigned therapy tasks must be performed within 30 days after the person begins work for our agency and has been trained and determined competent to perform all the tasks assigned. The	01440		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33169	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/19/2023
NAME OF PROVIDER OR SUPPLIER THE HARBORS SENIOR LIVING FRID		STREET ADDRESS, CITY, STATE, ZIP CODE 5300 4TH STREET NE FRIDLEY, MN 55421		
(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
01440	Continued From page 29 RN will directly supervise staff performing delegated nursing tasks and the appropriate health professional will supervise unlicensed staff performing any delegated treatments or assigned therapies. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440		
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); (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	01470		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33169	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/19/2023
NAME OF PROVIDER OR SUPPLIER THE HARBORS SENIOR LIVING FRID		STREET ADDRESS, CITY, STATE, ZIP CODE 5300 4TH STREET NE FRIDLEY, MN 55421		
(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
01470	Continued From page 30 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 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 three employees (registered nurse (RN)-A), received orientation to assisted living facility licensing requirements before providing services. This practice resulted in a level two violation (a violation that did not harm a resident's health or	01470		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33169	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/19/2023
NAME OF PROVIDER OR SUPPLIER THE HARBORS SENIOR LIVING FRID		STREET ADDRESS, CITY, STATE, ZIP CODE 5300 4TH STREET NE FRIDLEY, MN 55421		
(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
01470	Continued From page 31 safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: RN-A had a hire date of August 8, 2022, to provide supervision and oversight to unlicensed personnel and provide direct services residents. RN-A's employee record lacked the following required orientation: - overview of assisted living statutes; - review of provider's policies and procedures; - handling emergencies and using emergency services; - reporting maltreatment of vulnerable adults or minors; - assisted living bill of rights; - handling a resident complaints, reporting complaints, where to report; - consumer advocacy services; - review of types of assisted living services the employee would provide and providers scope of license; and - principles of person-centered planning/service delivery. On January 18, 2023, at 1:57 p.m., registered nurse (RN)-C stated staff were trained on required orientation topics in person however, the licensee was working on converting to EduCare (a training software system). In addition, RN-C stated they did not receive orientation from licensee because they also worked at another facility owned by the licensee's management company and was provided orientation at the	01470		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33169	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/19/2023
NAME OF PROVIDER OR SUPPLIER THE HARBORS SENIOR LIVING FRID		STREET ADDRESS, CITY, STATE, ZIP CODE 5300 4TH STREET NE FRIDLEY, MN 55421		
(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
01470	Continued From page 32 other location. The licensee's Orientation of Staff and Supervisors & Content policy dated August 1, 2021, indicated all staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to the residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
01540 SS=F	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED (3) for assisted living facilities with dementia care, direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by:	01540		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33169	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/19/2023
NAME OF PROVIDER OR SUPPLIER THE HARBORS SENIOR LIVING FRID		STREET ADDRESS, CITY, STATE, ZIP CODE 5300 4TH STREET NE FRIDLEY, MN 55421		
(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
01540	Continued From page 33 Based on interview and record review, the licensee failed to ensure direct-care staff completed at least eight hours of initial dementia care training within 80 working hours of the employment start date for one of three employees (registered nurse (RN)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee had a current Assisted Living Facility with Dementia Care (ALFDC) license effective August 1, 2022, through June 30, 2023. RN-C had a hire date of August 8, 2022, to provide supervision and oversight to unlicensed personnel and provide direct services residents. RN-C training records indicated RN-C completed 2.25 hours of dementia care training on the following courses: - Dementia - Communication - Reality; - Dementia - Problem Solving - Anxiety; and - Dementia - The Face of Dementia. RN-C's employee record lacked at least eight hours of initial training on the following required topics within 80 working hours of the employment start date: - an explanation of Alzheimer's disease and other dementias; - assistance with activities of daily living;	01540		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33169	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/19/2023
NAME OF PROVIDER OR SUPPLIER THE HARBORS SENIOR LIVING FRID		STREET ADDRESS, CITY, STATE, ZIP CODE 5300 4TH STREET NE FRIDLEY, MN 55421		
(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
01540	Continued From page 34 - problem solving with challenging behaviors; - communication skills; and - person-centered planning and service delivery. On January 18, 2023, at 2:01 p.m., RN-C stated staff were to complete the required dementia care training on EduCare (a training software system) within 120 hours after hire. RN-C stated they completed the required dementia care training at a different licensee and did not complete additional training with this licensee. In addition, RN-C stated, "I have worked in a geri [geriatric] behavioral health so I have a lot of training on that." The licensee's Dementia Training policy dated August 1, 2021, indicated supervisors of direct care staff will complete eight hours of initial training within 120 hours of the employment start date, and training would include the topics listed above. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01540		
01620 SS=E	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision	01620		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33169	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/19/2023
NAME OF PROVIDER OR SUPPLIER THE HARBORS SENIOR LIVING FRID		STREET ADDRESS, CITY, STATE, ZIP CODE 5300 4TH STREET NE FRIDLEY, MN 55421		
(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
01620	Continued From page 35 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) conducted ongoing resident assessment and reassessment, not to exceed 90 calendar days from the last date of the assessment for two of four residents (R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R2 R2 was admitted to the licensee and started receiving assisted living services on March 23, 2022.	01620		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33169	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/19/2023
NAME OF PROVIDER OR SUPPLIER THE HARBORS SENIOR LIVING FRID		STREET ADDRESS, CITY, STATE, ZIP CODE 5300 4TH STREET NE FRIDLEY, MN 55421		
(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
01620	Continued From page 36 R2's diagnoses included diabetes mellitus, hyperlipidemia (high cholesterol), and esophageal reflux (heartburn). R2's Service Plan - Addendum to Contract signed January 2, 2023, indicated R2 received assistance with ace wraps, ambulation, bathing, catheter care, dressing, housekeeping, incontinence care, laundry, meal assistance, medication administration, blood glucose monitoring, skin care, and toileting. R2's record included four assessments. The admission assessment dated March 23, 2022, 14-day assessment dated April 6, 2022, and two 90-day assessments dated September 4, 2022, and December 9, 2022. The assessment completed on April 6, 2022, indicted 151 days passed between re-assessment. The assessment completed on September 4, 2022, indicated 96 days passed between re-assessment. R3 R3 was admitted to the licensee July 24, 2020, and started receiving assisted living services August 1, 2021. R3's diagnoses included encephalitis (an inflammation of the brain usually caused due to infection that causes flu like symptoms), dementia, hypertension (HTN), atrial fibrillation, and Parkinson's disease. R3's Service Plan - Modification signed April 1, 2021, indicated R3 received assistance with activities, bathing, behavior management, dressing, mobility, housekeeping, incontinence care, meal assistance, medication administration,	01620		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33169	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 01/19/2023
NAME OF PROVIDER OR SUPPLIER THE HARBORS SENIOR LIVING FRID			STREET ADDRESS, CITY, STATE, ZIP CODE 5300 4TH STREET NE FRIDLEY, MN 55421		
(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
01620	Continued From page 37 oxygen delivery, and toileting. R3's record included three 90-day re-assessments dated March 1, 2022, August 20, 2022, and January 17, 2023. The assessments completed on March 1, 2022, and August 20, 2022, indicated 172 days passed between re-assessments. In addition, the assessments completed on August 20, 2022, and January 17, 2023, indicated 150 days passed between re-assessments. On January 18, 2023, at 2:05 p.m., RN-C stated assessments were completed prior to or on day of admission, 14-days, every 90 days, and when someone returns from a hospital. The evaluator inquired why multiple resident's assessments were completed after 90-days. RN-C stated, "I do not have an excuse other than it was missed by accident." The licensee's Assessments, Reviews & Monitoring policy dated August 1, 2021, indicated residents 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. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620			
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living	01640			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33169	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/19/2023
NAME OF PROVIDER OR SUPPLIER THE HARBORS SENIOR LIVING FRID		STREET ADDRESS, CITY, STATE, ZIP CODE 5300 4TH STREET NE FRIDLEY, MN 55421		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01640	Continued From page 38 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. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the current service plan included a signature or other authentication by the resident or resident's designated representative and the licensee to document agreement on the services to be provided for one of three residents (R4). 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).	01640		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33169	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/19/2023
NAME OF PROVIDER OR SUPPLIER THE HARBORS SENIOR LIVING FRID		STREET ADDRESS, CITY, STATE, ZIP CODE 5300 4TH STREET NE FRIDLEY, MN 55421		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01640	Continued From page 39 The findings include: R4 was admitted to the licensee and started receiving assisted living services November 4, 2022. R4's diagnoses included multiple sclerosis (a disabling disease of the brain and spinal cord), malnutrition, muscle weakness, dyspnea, and respiratory abnormality (shortness of breath), use of tube feeding, and asthma. R4's unsigned service plan printed January 17, 2023, indicated R4 received assistance with activities, bathing, bed mobility, bedmaking, dressing, grooming, housekeeping, laundry, linen change, medication administration, safety check, wheelchair use, tube feeding, and toileting. On January 19, 2023, at 2:26 p.m., RN-C stated, "we [staff] started to get it completed, but we just couldn't get his [R4] signature." The licensee's 6.08 Service Plan policy dated August 1, 2021, indicated within 14 days after the date that services are first provided to a resident, [the facility] will finalize a written service plan, and the service plan and any revisions shall include a signature or other authentication by [the facility] and by the resident, or resident representative. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01880 SS=D	144G.71 Subd. 19 Storage of medications	01880		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33169	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/19/2023
NAME OF PROVIDER OR SUPPLIER THE HARBORS SENIOR LIVING FRID		STREET ADDRESS, CITY, STATE, ZIP CODE 5300 4TH STREET NE FRIDLEY, MN 55421		
(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
01880	Continued From page 40 An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure all medications were securely locked in substantially constructed compartments that would permit only authorized personnel to have access for one of four residents (R6). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On January 18, 2023, at 7:57 a.m., the evaluator observed nystatin powder 100,000 units (U) / milliliter (ml) on the living room table of R6. R6's Treatment and Therapy Plan - Assessment dated January 18, 2023, indicated R6's medications were stored in the medication cart and the medication cart would be kept locked when not in attendance by an authorized medication passer. On January 18, 2023, at 8:12 a.m., unlicensed personnel (ULP)-G stated nystatin powder was left in R6's room so it could be applied when	01880		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33169	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/19/2023
NAME OF PROVIDER OR SUPPLIER THE HARBORS SENIOR LIVING FRID		STREET ADDRESS, CITY, STATE, ZIP CODE 5300 4TH STREET NE FRIDLEY, MN 55421		
(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
01880	Continued From page 41 cares were performed. On January 18, 2023, at 2:09 p.m., registered nurse (RN)-C stated all creams and powders should be kept in the top drawer of the medication cart unless the resident was assessed to self-administer. The licensee's Medication Storage dated August 1, 2021, indicated when medications are managed and stored by licensee, medications would be kept securely locked and authorized staff would only have access to stored medications. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01940 SS=F	144G.72 Subd. 3 Individualized treatment or therapy management For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that	01940		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33169	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/19/2023
NAME OF PROVIDER OR SUPPLIER THE HARBORS SENIOR LIVING FRID		STREET ADDRESS, CITY, STATE, ZIP CODE 5300 4TH STREET NE FRIDLEY, MN 55421		
(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
01940	Continued From page 42 will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for three of four residents (R3, R4, R9). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On January 17, 2023, at 10:30 a.m., during the entrance conference, licensed practical nurse (LPN)-B stated the licensee offered services to include oxygen management and blood glucose monitoring.	01940		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33169	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/19/2023
NAME OF PROVIDER OR SUPPLIER THE HARBORS SENIOR LIVING FRID		STREET ADDRESS, CITY, STATE, ZIP CODE 5300 4TH STREET NE FRIDLEY, MN 55421		
(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
01940	Continued From page 43 R3 R3 was admitted to the licensee July 24, 2020, and started receiving assisted living services August 1, 2021. R3's diagnoses included encephalitis (an inflammation of the brain usually caused due to infection that causes flu like symptoms), dementia, hypertension (HTN), atrial fibrillation, and Parkinson's disease. R3's Service Plan - Modification signed April 1, 2021, indicated R3 received assistance with activities, bathing, behavior management, dressing, mobility, housekeeping, incontinent care, meal assistance, medication administration, oxygen delivery, and toileting. On January 18, 2023, at 7:52 a.m., the evaluator observed oxygen administration via nasal cannula to R3. R3' provider order dated August 18, 2022, included oxygen at 2 liters (L) / minute via nasal cannula on at bedtime, off in the morning, ok to use as needed when lying in bed for shortness of breath (SOB) or labored breathing. R3's Service Recap Summary - Month dated January 1, 2023, through January 31, 2023, included oxygen delivery. R3's Med Admin Summary - Actual -Month dated January 1, 2023, through January 31, 2023, lacked information related to oxygen. R3's Treatment and Therapy Plan - Assessment dated January 18, 2023, lacked information related to oxygen.	01940		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33169	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/19/2023
NAME OF PROVIDER OR SUPPLIER THE HARBORS SENIOR LIVING FRID		STREET ADDRESS, CITY, STATE, ZIP CODE 5300 4TH STREET NE FRIDLEY, MN 55421		
(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
01940	Continued From page 44 R3's treatment and therapy plan lacked the following information: - documentation of specific resident instructions relating to the treatments or therapy administration; - procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and - any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. R4 R4 was admitted to the licensee and started receiving assisted living services November 4, 2022. R4's diagnoses included multiple sclerosis (a disabling disease of the brain and spinal cord), malnutrition, muscle weakness, dyspnea, and respiratory abnormality (shortness of breath), use of tube feeding, and asthma. R4's Service Plan dated January 18, 2023, indicated R4 received assistance with activities, bathing, bed mobility, bedmaking, dressing, grooming, housekeeping, laundry, linen change, medication administration, safety check, wheelchair use, tube feeding, and toileting. On January 18, 2023, from 8:19 a.m. to 8:40 a.m., the evaluator observed ULP-J provide care to R4, including oxygen administration.	01940		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33169	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/19/2023
NAME OF PROVIDER OR SUPPLIER THE HARBORS SENIOR LIVING FRID		STREET ADDRESS, CITY, STATE, ZIP CODE 5300 4TH STREET NE FRIDLEY, MN 55421		
(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
01940	Continued From page 45 R4' provider order dated December 28, 2022, lacked orders for oxygen use or tube feedings. R4's Medication Administration Record (MAR) dated January 1, 2023, through January 31, 2023, included twice a day osmolite 1.5 cal (a complete balanced nutrition formula for tube-fed patients) tube feedings however lacked information related to oxygen. R4's treatment and therapy plan lacked the following information: -services for tube feedings; -services for oxygen therapy; - documentation of specific resident instructions relating to the treatments or therapy administration; - procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and - any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. R9 R9 was admitted to the licensee and began receiving services on September 7, 2022. R9 diagnoses included hypertension (high blood pressure) and acute respiratory failure. R9's service plan dated September 9, 2022,	01940		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33169	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/19/2023
NAME OF PROVIDER OR SUPPLIER THE HARBORS SENIOR LIVING FRID		STREET ADDRESS, CITY, STATE, ZIP CODE 5300 4TH STREET NE FRIDLEY, MN 55421		
(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
01940	Continued From page 46 indicated R9 received assistance with bathing, dressing, grooming, linen change, medication administration, recording blood pressure and weight, safety checks, toileting, transfers, and wheelchair use. The service plan did not indicate R9 was receiving oxygen management or blood glucose monitoring. R9's preadmission orders dated September 2, 2022, indicated daily blood glucose checks and oxygen via nasal cannula 1 liter per minute. R9's medication administration record indicated R9 was receiving services to include daily blood glucose monitoring and oxygen via nasal cannula 1 liter per minute. On January 18, 2023, at 7:45 a.m., the evaluator observed unlicensed personnel (ULP)-K check R9's blood glucose. R9's Treatment and Therapy Plan Assessment dated (as of) January 18, 2023, did not indicate R9 was receiving treatments or therapies to include blood glucose monitoring or oxygen management. The treatment and therapy plan lacked the following regarding these treatment or therapies: - a statement of the type of services that will be provided; -documentation of specific resident instructions relating to the treatments or therapy administration; -indemnification of treatment or therapy tasks that will be delegated to unlicensed personnel; -procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and -any resident-specific requirements relating to	01940		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33169	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/19/2023
NAME OF PROVIDER OR SUPPLIER THE HARBORS SENIOR LIVING FRID		STREET ADDRESS, CITY, STATE, ZIP CODE 5300 4TH STREET NE FRIDLEY, MN 55421		
(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
01940	Continued From page 47 documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. On January 18, 2023, at 2:10 p.m., registered nurse (RN)-C stated treatment therapy components would be located on the resident's care plan. In addition, RN-C stated if a resident received oxygen (O2) they would have O2 saturations (sats) taken once per shift and documentation of how many liters (L) resident received to monitor the treatment. On January 19, 2023, at 11:40 p.m., registered nurse (RN)-C stated treatments provided to the residents would be included in the service plan. The licensee's Treatment & Therapy Management Plan policy dated August 1, 2021, indicated for each resident at [the facility] receiving management of ordered or prescribed treatments or therapy services, the facility will prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. [The facility] will develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: a. A statement of the type of services that will be provided b. Documentation of specific resident instructions relating to the treatments or therapy administration c. Identification of treatment or therapy tasks that will be delegated to unlicensed personnel d. Procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services e. any resident specific requirements relating to	01940		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33169	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/19/2023
NAME OF PROVIDER OR SUPPLIER THE HARBORS SENIOR LIVING FRID		STREET ADDRESS, CITY, STATE, ZIP CODE 5300 4TH STREET NE FRIDLEY, MN 55421		
(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
01940	Continued From page 48 documentation of treatment and therapy received f. Verification that all treatment and therapy was administered as prescribed g. Monitoring of treatment or therapy to prevent possible complications or adverse reactions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure written or electronically recorded orders were obtained for one of one resident (R4) with treatments. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).	01970		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33169	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/19/2023
NAME OF PROVIDER OR SUPPLIER THE HARBORS SENIOR LIVING FRID		STREET ADDRESS, CITY, STATE, ZIP CODE 5300 4TH STREET NE FRIDLEY, MN 55421		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01970	Continued From page 49 The findings include: During the entrance conference on January 17, 2023, at approximately 10:30 a.m., licensed practical nurse (LPN)-B stated the licensee provided treatment or therapy management services for their residents. R4 was admitted to the licensee and started receiving assisted living services November 4, 2022. R4's diagnoses included multiple sclerosis (a disabling disease of the brain and spinal cord), malnutrition, muscle weakness, dyspnea, and respiratory abnormality (shortness of breath), use of tube feeding, and asthma. R4's Service Plan dated January 18, 2023, indicated R4 received assistance with activities, bathing, bed mobility, bedmaking, dressing, grooming, housekeeping, laundry, linen change, medication administration, safety check, wheelchair use, tube feeding, and toileting. On January 18, 2023, from 8:19 a.m. to 8:40 a.m., the evaluator observed unlicensed personnel (ULP)-J provide care to R4 including oxygen administration. R4's record did not include a treatment administration record (TAR) to identify oxygen administration services. R4's Medication Administration Record (MAR) dated January 1, 2023, through January 31, 2023, included twice a day tube feeding osmolite 1.5 cal (a complete balanced nutrition formula for tube feedings). R4's MAR indicated	01970		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33169	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/19/2023
NAME OF PROVIDER OR SUPPLIER THE HARBORS SENIOR LIVING FRID		STREET ADDRESS, CITY, STATE, ZIP CODE 5300 4TH STREET NE FRIDLEY, MN 55421		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01970	Continued From page 50 osmolite 1.5 cal had been administered by staff 34 times between January 1, 2023, and January 17, 2023. The MAR did not include the service of assistance with oxygen administration. R4' provider order dated December 28, 2022, lacked orders for oxygen use or tube feedings. On January 19, 2023, at 11:38 a.m., registered nurse (RN)-C stated a provider order was needed for any medication or treatment the licensee provided including oxygen. On January 19, 2023, at 2:25 p.m., RN-C acknowledged R4's record was missing current prescriber orders for tube feeding and oxygen and stated the licensee will would call the primary physician for clarification of orders. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970		
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.	02040		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33169	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/19/2023
NAME OF PROVIDER OR SUPPLIER THE HARBORS SENIOR LIVING FRID		STREET ADDRESS, CITY, STATE, ZIP CODE 5300 4TH STREET NE FRIDLEY, MN 55421		
(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
02040	Continued From page 51 This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to provide a safety risk assessment or hazard vulnerability assessment of the physical environment on and around the property for the facility. This deficient practice had the ability to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). Findings include: On January 17, 2023, at approximately 2:15 p.m., records were provided for review. Records were reviewed by survey staff on January 17, 2023, between 2:15 p.m. and 2:50 p.m. Record review of the available documentation indicated that the licensee had not performed a safety risk assessment or hazard vulnerability assessment with mitigation factors on and around the property for the physical environment. On January 17, 2023, at approximately 3:00 p.m., the licensed assisted living director (LALD)-A verified that the licensee was not able to provide a safety risk assessment or hazard vulnerability assessment with mitigation factors for the physical environment on and around the property. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33169	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/19/2023
NAME OF PROVIDER OR SUPPLIER THE HARBORS SENIOR LIVING FRID		STREET ADDRESS, CITY, STATE, ZIP CODE 5300 4TH STREET NE FRIDLEY, MN 55421		
(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 SS=F	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care standards, medical or nursing standards for four of four residents (R3, R7, R9, R10) who utilized oxygen. 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 January 17, 2023, between 12:20 p.m. and 2:15 p.m., during facility tour, the Minnesota Department of Health (MDH) engineer observed unsecured oxygen cylinders that were not stored properly in noncombustible racks in R7, R9, and R10's apartments. On January 18, 2023, at 7:53 a.m., the evaluator observed an oxygen concentrator and one unsecured oxygen cylinder that was not stored properly in a noncombustible rack in R3's room.	02310		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33169	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/19/2023
NAME OF PROVIDER OR SUPPLIER THE HARBORS SENIOR LIVING FRID		STREET ADDRESS, CITY, STATE, ZIP CODE 5300 4TH STREET NE FRIDLEY, MN 55421		
(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 53 On January 18, 2023, at 8:50 a.m., the evaluator observed one concentrator, one oxygen cylinder in a wheeled oxygen cart, and one unsecured oxygen cylinder that was not stored properly in a noncombustible rack next to the closet in R7's living room. On January 18, 2023, at 11:19 a.m., unlicensed personnel (ULP)-I stated they were trained to store oxygen cylinders upright and in a compartment. The evaluator inquired why the residents listed above did not have oxygen cylinders stored in a rack. ULP-I stated it was the responsibility of the med (medication) passer to store oxygen correctly. On January 18, 2023, at 2:10 p.m., registered nurse (RN)-C stated staff were trained to store oxygen cylinders in a resident's apartment and in a rack to prevent oxygen cylinders from tipping over. Minnesota Department of Health (MDH) Oxygen Cylinder Storage Requirements dated April 16, 2020, recommended cylinders be secured with chains or racks to prevent cylinders from falling over. The licensee's Oxygen policy dated August 1, 2021, indicated oxygen cylinders and vessels must remain upright at all times. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33169	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/19/2023
NAME OF PROVIDER OR SUPPLIER THE HARBORS SENIOR LIVING FRID		STREET ADDRESS, CITY, STATE, ZIP CODE 5300 4TH STREET NE FRIDLEY, MN 55421		
(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
03090	Continued From page 54	03090		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors 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. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure the required notice was posted at the main entryway of the facility to display statutory language to disclose electronic monitoring activity. This had the potential to affect all of the licensee's residents, staff, and visitors. 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 the residents). The finding include: On January 17, 2023, at 10:00 a.m., the evaluator observed signage posted regarding electronic monitoring lacked the required verbiage. The sign posted in the front entryway read, "premises protected by 24-hour audio and video surveillance, by entering you agree to be recorded."	03090		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33169	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/19/2023
NAME OF PROVIDER OR SUPPLIER THE HARBORS SENIOR LIVING FRID		STREET ADDRESS, CITY, STATE, ZIP CODE 5300 4TH STREET NE FRIDLEY, MN 55421		
(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
03090	Continued From page 55 On January 18, 2023, at 2:13 p.m., registered nurse (RN)-C stated they were unaware of the requirement. On January 19, 2023, at 10:45 a.m., licensed assisted living director (LALD)-A stated she was not aware the electronic monitoring sign had to be exact verbiage. The licensee's Electronic Monitoring policy dated August 1, 2021, indicated signs are installed at each facility entrance accessible to visitors that state: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons or activities." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	03090		



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

Type: Full
Date: 01/17/23
Time: 12:56:38
Report: 8058231013

Food and Beverage Establishment Inspection Report

Page 1

Location:

The Harbors Senior Living Frid
5300 4th Street Ne
Fridley, MN55421
Anoka County, 02

Establishment Info:

ID #: 0038366
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7637628990
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.

UNMARKED OPENED DELI MEAT

Comply By: 01/17/23

Surface and Equipment Sanitizers

Hot Water: = --- at 173 Degrees Fahrenheit

Location: DISH MACHINE

Violation Issued: No

Quaternary Ammonia: = 200 PPM at --- Degrees Fahrenheit

Location: DISPENSER

Violation Issued: No

Food and Equipment Temperatures

Process/Item: STIRFRY

Temperature: 163 Degrees Fahrenheit - Location: HOT WELL

Violation Issued: No

Process/Item: GRAPES

Temperature: 41 Degrees Fahrenheit - Location: COOLER

Violation Issued: No

Type: Full
Date: 01/17/23
Time: 12:56:38
Report: 8058231013
The Harbors Senior Living Frid

Food and Beverage Establishment Inspection Report

Page 2

Process/Item: GROUND BEEF
Temperature: 41 Degrees Fahrenheit - Location: COOLER
Violation Issued: No

Process/Item: TOMATO
Temperature: 41 Degrees Fahrenheit - Location: PREP
Violation Issued: No

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

COMMERCIAL KITCHEN

HRD REP. WENDY ROBARGE

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 8058231013 of 01/17/23.

Certified Food Protection Manager LAURA CORT

Certification Number: 113319 Expires: 09/27/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
Establishment Representative

Signed: 
Inspector Number 8058
Sanitarian 3
MDH Metro Office
651 201 4500
health.foodlodging@state.mn.us