



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

July 2, 2024

Licensee

Prime Time Essential Care LLC
3870 Eastwood Road Southeast
Rochester, MN 55904

RE: Project Number(s) SL40089015

Dear Licensee:

This is your **official notice** that you have been **granted your assisted living facility license**. Your license effective and expiration dates remain the same as on your provisional license. Your updated status will be listed on the license certificate at renewal and **this letter serves as proof** in the meantime. If you have not received a letter from us with information regarding renewing your license within 60 days prior to your expiration date, please contact us at (651) 201-5273 or by email at Health.assistedliving@state.mn.us.

The Minnesota Department of Health completed an initial survey on June 5, 2024, for the purpose assessing compliance with state licensing statutes. At the time of the survey, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G.

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

STATE CORRECTION ORDERS

The enclosed State Form documents the state correction orders. The Department of Health documents state correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Home Care 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 are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

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

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.

- Identify how the area(s) of noncompliance was corrected for all of the provider's residents/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 correction order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

To submit a reconsideration request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **<https://forms.office.com/g/Bm5uQEPhVa>**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,



Jodi Johnson, Supervisor
tate Evaluation Team
Email: Jodi.Johnson@state.mn.us
Telephone: 507-344-2730 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40089	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/05/2024
NAME OF PROVIDER OR SUPPLIER PRIME TIME ESSENTIAL CARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 3870 EASTWOOD ROAD SOUTHEAST ROCHESTER, MN 55904			
(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: SL40089015-0 On June 3, 2024, through June 5, 2024, the Minnesota Department of Health conducted an intial survey at the above provider, and the following correction orders are issued. At the time of the survey, there were two residents; two receiving services under the provider's provisional Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
0 110 SS=C	144G.10 Subdivision 1a Assisted living director license required	0 110			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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0 110	Continued From page 1 Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the licensed assisted living director (LALD) was listed as the Director of Record for the licensee. This had the potential to affect all the licensee's residents, staff, and visitors. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: On June 3, 2024, at 10:30 a.m. during the entrance conference, LALD-A stated she believed she was listed as the director of record for the facility license. On June 3, 2024, at 12:07 p.m. the surveyor checked LALD-A's director of record status on the Board of Executives for Long Term Services and Supports (BELTSS) website and noted she was not affiliated or listed as the director of record for the licensee. On June 3, 2024, at 12:10 p.m. The surveyor emailed a BELTSS representative to clarify the	0 110			

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0 110	Continued From page 2 licensee's status with a LALD affiliation. At 12:17 p.m., the BELTSS representative responded that the licensee did not have a LALD listed as the director of record and provided instructions in how this was accomplished. On June 3, 2024, at 12:20 p.m. LALD-A stated she thought she had completed all steps for the LALD process. The surveyor provided LALD-A with the instructions from the BELTSS representative to be listed as the director of record for the facility's license. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 110			
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. 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	0 480			

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0 480	Continued From page 3 or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated June 3, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480			
0 650 SS=F	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057.	0 650			

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0 650	Continued From page 4 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee records contained the required content for one of one employee (house manager (HM)-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, 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: HM-C started employment on July 1, 2023, to provide direct care services to the licensee's residents. On June 4, 2024, at 9:07 a.m. HM-C was observed to administer medications to R2. HM-C indicated she received training by the licensee's registered nurse (RN) and had since been observed by the RN. HM-C's employee record included a 30-day evaluation dated August 3, 2023, as completed by the LALD; however, the record lacked evidence of a 30-day RN supervisory evaluation of ULP performing nurse delegated tasks had been completed. On June 4, 2024, at 1:20 p.m. clinical nurse supervisor (CNS)-B indicated he had completed 30-day RN supervision evaluations of the unlicensed staff; however, he had not	0 650			

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0 650	Continued From page 5 documented the evaluations as there was not a form to complete. CNS-B stated no unlicensed personnel (ULP) had record of the 30-day RN evaluation. The licensee's Supervision of Staff-delegated services dated July 1, 2023, indicated direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for {licensee name} and first performs the delegated tasks for residents and thereafter as needed based on performance. Documentation of supervision activities will be retained in the employee's record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650			
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of	0 660			

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0 660	Continued From page 6 compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included a facility TB risk assessment, documentation of a completed health history and symptom screening, including completion of a two-step TST (tuberculin skin test) or other evidence of TB screening such as a blood test for one of one employee (house manager (HM)-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, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: TB PREVENTION PROGRAM The licensee's TB Risk Assessment Worksheet for Health Care settings was last dated July 6, 2023, and indicated the licensee was a low-risk health care setting. On June 3, 2024, at 10:45 a.m. house manager (HM)-C indicted she and the registered nurse oversaw the TB assessment and she managed the employee files. HM-C	0 660			

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0 660	Continued From page 7 HM-C's employee record indicated a hire date of July 1, 2023, to provide direct care services to the licensee's residents. On June 4, 2024, at 9:07 a.m. HM-C was observed to set up and administer medications to R2. HM-C's employee file included a symptom screening dated September 19, 2020, and a first step TST with negative results dated September 21, 2020; however, HM-C had not completed a symptom screening and testing since she was hired on July 1, 2023. On June 4, 2024, at 1:15 p.m. HM-C stated she thought she had completed both steps of the TST, but it was done a couple years ago. HM-C indicated she had not completed TB screening or testing since she started employment with the licensee. The licensee's Tuberculosis screening policy dated June 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. Baseline (upon hire) screening will be completed, but serial (annual) screening will only be required with increased occupational risk or exposure. Screening will be conducted as follows: 1. New staff will be screened for active signs of TB using the Baseline TB Screening Tool for HCWs. 2. New staff will have an IGRA blood test or a two-step Mantoux conducted with results documented on the Baseline TB Screening Tool for HCWs. 3. No staff will be permitted to begin work where	0 660			

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0 660	Continued From page 8 the work involves sharing the air space with residents until the negative results of the first Mantoux are read and documented or a negative IGRA blood test result is received and documented. 4. Staff TB screening results will be kept in each employee medical file. 5. Staff should be screened for signs and symptoms on an annual basis. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660			
0 690 SS=C	144G.43 Subdivision 1 Resident record (a) Assisted living facilities must maintain records for each resident for whom it is providing services. Entries in the resident records must be current, legible, permanently recorded, dated, and authenticated with the name and title of the person making the entry. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure entries in one of one resident's record (R1) were authenticated by the title of the person making the entry. 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).	0 690			

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0 690	Continued From page 9 The findings include: R1 R1's Individual Abuse Prevention Plan dated July 6, 2023, included the house manager's signature, but lacked her credentials/title. R1's unnamed document, known as R1's task record dated May 5, 2024, through May 31, 2024, included several initials; however, the record lacked staff signatures with credentials/titles. R1's progress note entries dated July 23, 2023, through May 31, 2024, lacked any indication of who entered/wrote the progress notes and lacked signatures and staff credentials. On June 3, 2024, at 1:15 p.m. house manager (HM)-C indicated the task records used by the licensee did not include a signature page or credentials to match the staff initials found on the documents. On June 4, 2024, at 1:30 p.m. house manager (HM)-C indicated she completed R1's progress note entries found in R1's record. She stated she had not thought about signing each entry as it was completed electronically. The licensee's Resident Record-Documentation policy dated August 1, 2021, indicated all documentation must include the signature and title of the person who performed the service or administered the medication, treatment, or therapy. Initials may be used if there is a completed signature page included in the documentation. No further information was provided.	0 690			

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0 690	Continued From page 10	0 690			
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional;	0 730			

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0 730	Continued From page 11 (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure documentation of content in the resident's record as required for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was admitted to the facility under the facility's Provisional Assisted Living Facility (PALF) license on July 1, 2023, with diagnoses including type 2 diabetes, coronary artery aneurysm, epilepsy/recurrent seizures, depression, heart disease, chronic respiratory failure, and hypothyroidism.	0 730			

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NAME OF PROVIDER OR SUPPLIER PRIME TIME ESSENTIAL CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3870 EASTWOOD ROAD SOUTHEAST ROCHESTER, MN 55904		
(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
0 730	Continued From page 12 R1's Service Plan dated April 5, 2024, indicated he received medication administration, assistance with dressing, oral hygiene, grooming, toileting, bathing, reminders for exercises, eating assistance, anxiety management, and lymphedema wraps. On June 3, 2024, at 12:00 p.m. the surveyor requested all registered nurse (RN) assessments completed since R1's admission date. The following assessments were provided: -July 1, 2023-admission assessment, page one included the additional date of August 4, 2023, with a handwritten note by the RN-" reassessment after a hospitalization for pneumonia"; -November 3, 2023, as a 90-day assessment with an additional date on page one indicating an assessment for February 1, 2024; and -May 1, 2024, 90-day assessment On June 4, 2024, at 9:25 a.m. the surveyor observed house manager (HM)-C administer R1's oral, topical, and inhaled medications. On June 4, 2024, at 1:15 p.m. HM-C provided R1's Progress Notes dated July 23, 2023, through May 31, 2024. The Progress notes lacked a signature/authentication of the staff who wrote the notes. HM-C indicated she entered each note. The progress notes included: -July 23, 2023, [R1] went to the ER for rectal bleeding. He stated he has seen rectal bleeding in his stool for five 5 days. Discharged same day and instructed to follow up with primary doctor. House manager will schedule the follow up appointment. - July 28, 2023, [R1] was seen at primary for dyspnea multifactorial [shortness of breath], hemorrhage gastrointestinal and hematochezia	0 730			

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0 730	Continued From page 13 [bleeding bowel]. Primary increased torsemide dose to 40 mg daily for tomorrow and Sunday. [pharmacy name] notified. MARS [medication administration record] updated; -August 4, 2023, [On] July 27, 2023, through August 3, 2023, [R1] hospitalized, Started on Acetic acid for dermatitis wound care and cefdinir for pneumonia. Epinephrine shots added, self-administered. MARS updated; staff trained on use; -January 5, 2024, ER visit on January 2, 2024, for abdominal pain; -April 5, 2024, ER visit, [R1] woke up with chest discomfort and staff gave him 0.4 mg tablet of Nitroglycerin. Staff reported ineffective. Staff admitted to ER and discharged on April 5, 2024; -April 19, 2024, On April 15, 2024, [R1] had oral surgery, teeth extraction was successful. Prescribed oxycodone by MD, 5 milligram [mg] doses. Staff notified. [R1] was also admitted to ER for bleeding in mouth from surgery on April 15, 2024, Discharged same day; -April 29, 2024, [R1] visited ER on April 27, 2024, complained of mild nausea and hematemesis. Admitted same day. Discharged on April 29, 2024, and sutures were removed per residents' request; -May 8, 2024, ER visit May 5, 2025, for ongoing oral bleeding, with instructions to continue salt and water rinses multiple times of day. On May 7, 2024, [R1] had ED follow up with ulcer peptic and was started on pantoprazole for GERD [gastroesophageal reflux disease] symptoms. MARS updated; and -May 31. 2024, [R1] was presented at the ER with undifferentiated spells. Released from ER. On May 31, 2024., [R1] went into the ER for abdominal pain. Diagnosis was a UTI. Prescribed levofloxacin 750 mg tablets for a period of 10 days. MARS updated.	0 730			

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0 730	Continued From page 14 R1's record included hospital/emergency room (ER) discharge summaries to include: -January 2, 2024,-ER visit for flank (lower back) pain, abdominal pain; -April 15, 2024, for oral surgery and subsequent ER visit for ongoing oral bleeding; -April 27, 2024, through April 29, 2024, hospitalization for nausea, hematemesis (vomiting blood); -May 31, 2024, for abdominal pain, with diagnoses of kidney mass and urinary tract infection (UTI) The licensee's registered nurse (RN) failed to complete a comprehensive assessment for a change in condition regarding the above listed hospitalizations/ER visits. Furthermore, the RN failed to provide documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional. On June 4, 2024, at 1:20 p.m. clinical nurse supervisor (CNS)-B stated he had not completed a change in condition assessment for the hospitalizations as listed. He stated R1 went to the hospital/ER so often and at times was sent home with no changes, he had not considered completing assessments with each visit. Furthermore, CNS-B stated he had not completed a progress note with the hospital stays or ER trips as listed. The licensee's Resident Record Information and Content policy dated August 1, 2021, indicated resident records must include documentation of significant changes in the resident's status and actions taken in response to the needs of the	0 730			

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0 730	Continued From page 15 resident, including reporting to the appropriate supervisor or health care professional. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 730			
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: Based on observation and interview, the licensee failed to install portable fire extinguishers as required by statute. This deficient condition 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	0 790			

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0 790	Continued From page 16 or has the potential to affect a large portion or all of the residents). The findings include: On June 5, 2024, at 10:30 a.m., survey staff toured the home with unlicensed personnel (ULP)-D. During the tour, survey staff observed the following: 1. The fire extinguisher in the kitchen was stored on top of a rack. 2. The fire extinguisher in the basement was stored on a counter in the office area. Fire extinguishers must be properly mounted and installed to prevent them from being moved or damaged. During the facility tour interview on June 5, 2024, ULP-D verified the fire extinguishers were not properly installed. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790			
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	0 810			

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0 810	Continued From page 17 or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to develop fire safety and evacuation plan with the required content. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On June 5, 2024, at 10:30 a.m., survey staff toured the home with unlicensed personnel	0 810			

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0 810	Continued From page 18 (ULP)-D. During the tour, survey staff observed the following: 1. The FSEP floor plan for the facility labeled four rooms as bedrooms. 2. Numbers were posted at each bedroom door, identified as 1, 2, 3, and 4. On June 5, 2024, ULP-D provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. On June 6, 2024, the licensee emailed additional documentation. FIRE SAFETY AND EVACUATION PLAN Record review of the available documentation indicated the licensee failed to include room numbers identifying the location of resident bedrooms on the fire safety and evacuation floor plan. Resident sleeping room numbers are required to be included on the fire safety and evacuation floor plan and used with the numbers installed at resident sleeping room doors to provide efficient communication for exiting in the event of a fire or similar emergency. The door leading into the attached garage from the home was designated as an exit in the Primetime Living FSEP: Eastwood. Emergency exits are required to lead directly to the exterior of the building and not through a higher hazard room. The Fire Emergency section in the 1.05 Handling of Emergencies and Use of Emergency Services document dated July 1, 2023, inappropriately referenced smoke compartment doors, fire sprinklers, fire doors on magnetic holders, and a fire panel with an alarm system wired directly to the fire station. This section inappropriately directs the building occupants to stay behind fire doors, but labeled fire doors were not observed during the facility tour. During an interview on June 5, 2024, at 10:35 a.m., ULP-D verified the FSEP did not include the	0 810			

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0 810	Continued From page 19 required detail and contained inaccurate information. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810			
01620 SS=E	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an 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) completed a 14-day comprehensive	01620			

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01620	Continued From page 20 assessment; failed to complete a comprehensive assessment for a change in condition; and failed to clearly indicate assessment information with ongoing 90-day assessments for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1 was admitted to the facility under the facility's Provisional Assisted Living Facility (PALF) license on July 1, 2023, with diagnoses including type 2 diabetes, coronary artery aneurysm, epilepsy/recurrent seizures, depression, heart disease, chronic respiratory failure, and hypothyroidism. R1's Service Plan dated April 5, 2024, indicated he received services to include medication administration, assistance with dressing, oral hygiene, grooming, toileting, bathing, reminders for exercises, eating assistance, anxiety management, and lymphedema wraps. On June 3, 2024, at 12:00 p.m. the surveyor requested all RN assessments completed since R1's admission date. The following assessments were provided: -July 1, 2023-admission assessment, page one included the additional date of August 4, 2023,	01620			

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01620	Continued From page 21 with a handwritten note by the RN-" reassessment after a hospitalization for pneumonia"; -November 3, 2023, as a 90-day assessment with an additional date on page one indicating an assessment for February 1, 2024; and -May 1, 2024, 90-day assessment On June 4, 2024, at 1:15 p.m. house manager (HM)-C provided R1's Progress Notes dated July 23, 2023, through May 31, 2024. The Progress notes lacked a signature/authentication of the staff who wrote the notes. HM-C indicated she entered each note. The progress notes included: -July 23, 2023, [R1] went to the ER for rectal bleeding. He stated he has seen rectal bleeding in his stool for five days. Discharged same day and instructed to follow up with primary doctor. House manager will schedule the follow up appointment. - July 28, 2023, [R1] was seen at primary for dyspnea multifactorial [shortness of breath], hemorrhage gastrointestinal and hematochezia [bleeding bowel]. Primary increased torsemide dose to 40 mg daily for tomorrow and Sunday. [pharmacy name] notified. MARS [medication administration record] updated; -August 4, 2023, [On] July 27, 2023, through August 3, 2023, [R1] hospitalized, Started on Acetic acid for dermatitis wound care and cefdinir for pneumonia. Epinephrine shots added, self-administered. MARS updated; staff trained on use; -January 5, 2024, ER visit on January 2, 2024, for abdominal pain; -April 5, 2024, ER visit, [R1] woke up with chest discomfort and staff gave him 0.4 mg Tablet of Nitroglycerin. Staff reported ineffective. Staff admitted to ER and discharged on April 5, 2024; -April 19, 2024, On April 15, 2024, [R1] had oral	01620			

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01620	Continued From page 22 surgery, teeth extraction was successful. Prescribed oxycodone by MD, 5 milligram [mg] doses. Staff notified. [R1] was also admitted to ER for bleeding in mouth from surgery on April 15, 2024, Discharged same day; -April 29, 2024, [R1] visited ER on April 27, 2024, complained of mild nausea and hematemesis. Admitted same day. Discharged on April 29, 2024, and sutures were removed per residents' request; -May 8, 2024, ER visit May 5, 2025, for ongoing oral bleeding, with instructions to continue salt and water rinses multiple times of day. On May 7, 2024, [R1] had ED follow up with Ulcer peptic and was started on pantoprazole for GERD symptoms. MARS updated; and -May 31. 2024, [R1] was presented at the ER with undifferentiated spells. Released from ER. On May 31, 2024., MB went into the ER for abdominal pain. Diagnosis was a UTI. Prescribed levofloxacin 750 mg tablets for a period of 10 days. MARS updated. 14 DAY ASSESSMENT R1's record included an admission assessment with the first page dated July 1, 2023. This same assessment's first page included a second date of August 4, 2023, with a handwritten note by the RN, "reassessed after a hospitalization for pneumonia". R1's record lacked a 14-day assessment as required. On June 3, 2024, at 1:30 p.m. clinical nurse supervisor CNS-B stated he had not completed a 14-day RN assessment. RN ASSESSMENT FOR A CHANGE IN CONDITION	01620			

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01620	Continued From page 23 R1's record included hospital/emergency room (ER) discharge summaries to include: -January 2, 2024, -ER visit for flank (lower back) pain, abdominal pain; -April 15, 2024, for oral surgery and subsequent ER visit for ongoing oral bleeding; -April 27, 2024, through April 29, 2024, hospitalization for nausea, hematemesis (vomiting blood); -May 31, 2024, for abdominal pain, with diagnoses of kidney mass and urinary tract infection (UTI) The licensee's RN failed to complete a comprehensive assessment for a change in condition regarding the above listed hospitalizations/ER visits. On June 4, 2024, at 1:20 p.m. CNS-B stated he had not completed a change in condition assessment for the hospitalizations as listed. He stated R1 went to the hospital/ER so often and at times was sent home with no changes, he had not considered completing assessments with each visit. Furthermore, CNS-B stated he had not completed a progress note with the hospital stays or ER trips. ONGOING RN COMPREHENSIVE ASSESSMENTS-COMBINED R1's record included two RN assessments indicating two assessment dates on each assessment. The combined assessments included: -July 1, 2023, admission assessment and August 4, 2023, reassessment after a hospitalization (change in condition) both dates on the first page of the assessment. -November 1, 2023, assessment (90 day) and February 1, 2024, assessment (90 day), both	01620			

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01620	Continued From page 24 dates listed on the first page of the assessment. The combined assessments listed above included the RN signature once on each assessment; however, the RN failed to indicate any or no changes with the additional second assessment. On June 4, 2024, at 1:20 p.m. clinical nurse supervisor (CNS)-B stated he used the same assessment a couple of times and stated R1's assessment information had not changed. CNS-B reviewed the assessments and indicated the assessments were unclear as to what was assessed and did not indicate there were no changes. He stated he should have completed separate assessments to make it clear. The licensee's Assessments, Reviews, and Monitoring policy dated June 2021, indicated: -the initial nursing assessment or reassessment must include all the elements of the uniform assessment tool as required, conducted in person (unless see #2), be in writing, dated, and signed by the registered nurse who conducted the assessment. -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. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620			

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01650	Continued From page 25	01650			
01650 SS=D	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the service plan included all required content for one of two residents (R1) who received services. This practice resulted in a level two violation (a	01650			

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NAME OF PROVIDER OR SUPPLIER PRIME TIME ESSENTIAL CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3870 EASTWOOD ROAD SOUTHEAST ROCHESTER, MN 55904		
(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
01650	Continued From page 26 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 R1 was admitted under the facility's Provisional Assisted Living Facility License (PALF) on July 1, 2023. R1's Service Plan dated April 5, 2024, indicated he received medication administration, assistance with dressing, oral hygiene, grooming, toileting, bathing, reminders for exercises, eating assistance, anxiety management, and lymphedema wraps. On June 4, 2024, at 9:25 a.m. house manager (HM)-C was observed to administer medications and assisted R1 with checking his blood sugar, disposed of the blood sugar test strip and lancet (used to poke the finger) and recorded the blood sugar level in R1's record. At 9:35 a.m., HM-C applied lotion to R1's legs and then donned compression stockings and lymphedema wraps to both lower extremities. HM-C stated R1's Service Plan did not include the task of assisting with R1's blood sugar check as he did most of the procedure independently. HM-C stated staff prepared the blood sugar monitoring equipment for R1, observed him completing the finger poke and guided him if there was not enough blood for the glucometer to accurately measure the blood sugar. HM-C stated the staff disposed the test	01650			

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01650	Continued From page 27 strip and lancet and recorded the blood sugar level in R1's record. R1's unnamed, document known as the task record dated May 5, 2024, through May 31, 2024, included the tasks of: - daily (morning) blood sugar check (record results); - daily (morning) apply/don circaid lymphedema wraps and compression stockings to both legs and encourage elevation of legs; - daily (evening) remove the lymphedema wraps and apply lotion/Vaseline to both legs; and - assistance with transfers with use of gait belt for transfers and with standing from sitting position. R1's medication administration record (MAR) dated May 2024, included the treatment of lymphedema wraps and compression stockings (on in the morning, off in the evening). R1' Service plan lacked the services of daily blood sugar check and donning/removing R1's compression stockings. R1's service plan included the services of hands-on transfers, lymphedema wraps, treatments/exercises; however, it lacked the frequency of these services. On June 4, 2024, at 9:50 a.m. HM-C stated she had not realized the frequency of the transfers, lymphedema wraps and exercises was missing from R1's Service Plan. HM-C stated R1's lymphedema wraps included the compression stockings as a set and had not considered them to be separate, thus had not included the compression stockings with the lymphedema wraps in the Service Plan.	01650			

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01650	Continued From page 28 The licensee's Service Plan policy dated June 2021, indicated a service plan will include: -a description of the services that are to be provided based on the most recent assessment and resident preferences -fees for services to be provided -the frequency of each service to be provided based on the most recent assessment and resident preferences -an identification of staff or categories of staff who will be providing services (RN, LPN, unlicensed personnel, etc.) No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650			
01700 SS=D	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent	01700			

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01700	Continued From page 29 diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted a face-to-face medication management assessment to include all required content for one of one resident (R1) receiving medication management services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: During the entrance conference on June 3, 2024, licensed assisted living director (LALD)-A confirmed the licensee provided medication management services to both current residents receiving assisted living services. R1 was admitted to the facility under the facility's Provisional Assisted Living Facility (PALF) license on July 1, 2023, with diagnoses including type 2	01700			

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01700	Continued From page 30 diabetes, coronary artery aneurysm, epilepsy/recurrent seizures, depression, heart disease, chronic respiratory failure, and hypothyroidism. R1's Service Plan dated April 5, 2024, indicated he received the service of medication administration. On June 4, 2024, at 9:35 a.m. house manager (HM)-C was observed to administer R1's oral, topical, and inhaled medications. R1's Medication Administration Record (MAR) dated May 2024, included the following: -torsemide 20 milligrams (mg), one tablet at 10:00 a.m. -metoprolol succinate, 0.5 tablet at 10:00 a.m. -allopurinol 300 mg, one tablet at 10:00 a.m. -escitalopram 10 mg, one tablet at 10:00 a.m. -levetiracetam 1000 mg, two tablets at 10:00 a.m. and 8:00 p.m. -Clopidogrel 75 mg, one tablet at 10:00 a.m. -lisinopril 5 mg, one tablet at 10:00 a.m. -levothyroxine 112 micrograms (mcg), one tablet at 10:00 a.m. -phenobarbital 97.2 mg, one tablet at 10:00 a.m. and 8:00 p.m. -Pregabalin 300 mg, one capsule at 10:00 a.m. and 8:00 p.m. -Breo-Ellipta100-25mcg/dose, one puff at 10:00 a.m. -ketoconazole 2% cream at 10:00 a.m. and 8:00 p.m. (lacked location to apply) -levofloxacin 750 mg one tablet at 10:00 a.m. -warfarin (dose varied, date dependent) at 8:00 p.m. -atorvastatin 80 mg, one tablet at 8:00 p.m. The licensee's Medication book indicated a	01700			

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01700	Continued From page 31 section for R1 and included a list of his medications and side effects for each medication. R1's assessments dated July 1, 2023, August 4, 2023, November 3, 2023, February 1, 2024, and May 1, 2024, included a medication section labeled Diagnoses and Medications used as the medication assessment. The assessments included a section to list all current medications with dosages, routes, frequency, and reasons (indications). The entry for this section indicated "see medication list (MAR)". The assessments lacked an identification and review of all medications the resident was known to be taking, to include indications for medications. Furthermore, the assessments lacked the required content of interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. On April 3, 2024, at 1:55 p.m. clinical nurse supervisor (CNS)-B indicated he met regularly with R1 regarding medications, as R1 wanted to be well informed about his medications. CNS-B stated he had not documented these meetings/discussions and had not included indications for each medication in R1's record. The licensee's Medication Management Assessment Monitoring and Reassessment policy dated August 1, 2021, indicated {licensee name}, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber conduct an assessment to determine	01700			

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01700	Continued From page 32 what medication management services will be provided and how the services will be provided. The assessment must be conducted face-to-face with the resident by an RN and include: -identification and review of all medications the resident is known to be taking. -the review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. -the assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01700			
01760 SS=F	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not	01760			

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01760	Continued From page 33 administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to include the required content for documentation of medications administered for both licensee's residents (R1, R2). 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: R1 R1 began receiving services under the licensee's provisional Assisted Living license on July 1, 2023. R1's diagnoses included type two diabetes, coronary artery aneurysm, epilepsy/recurrent seizures, depression, heart disease, chronic respiratory failure, and hypothyroidism. R1's Service Plan dated April 5, 2024, indicated R1 received medication administration. On June 4, 2024, at 9:25 a.m. house manager (HM)-A was observed to administer oral, topical, and inhaled medications to R1. R1's signed medication orders dated February	01760			

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01760	Continued From page 34 20, 2024, and May 31, 2024, included one medication for generalized pain, one for gout, two for dry eyes, one for cholesterol, two blood thinners, one topical pain medication, one for anxiety, one for cough, , two for seizures, one for blood pressure, one to control heart rate, one for chest pain, one for nerve pain, one for constipation, one for fluid retention, one for thyroid, two antifungal topical medications, two inhalers for chronic respiratory failure, one injection for anaphylaxis and one antibiotic. R1's medication administration record (MAR) dated May 2024, indicated R1 received the following: -torsemide 20 milligrams (mg), one tablet at 10:00 a.m. -metoprolol succinate, 0.5 tablet at 10:00 a.m. -allopurinol 300 mg, one tablet at 10:00 a.m. -escitalopram 10 mg, one tablet at 10:00 a.m. -levetiracetam 1000 mg, two tablets at 10:00 a.m. and 8:00 p.m. -Clopidogrel 75 mg, one tablet at 10:00 a.m. -lisinopril 5 mg, one tablet at 10:00 a.m. -levothyroxine 112 micrograms (mcg), one tablet at 10:00 a.m. -phenobarbital 97.2 mg, one tablet at 10:00 a.m. and 8:00 p.m. -Pregabalin 300 mg, one capsule at 10:00 a.m. and 8:00 p.m. -Breo-Ellipta100-25mcg/dose, one puff at 10:00 a.m. -ketoconazole 2% cream at 10:00 a.m. and 8:00 p.m. (lacked location to apply) -levofloxacin 750 mg one tablet at 10:00 a.m. -warfarin (dose varied, date dependent) at 8:00 p.m. -atorvastatin 80 mg, one tablet at 8:00 p.m. R2	01760			

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01760	Continued From page 35 R2 began receiving services under the licensee's provisional Assisted Living License on March 13, 2024. R2's diagnoses included paranoid schizophrenia, heart disease, seizure disorder, urinary retention with recurrent urinary tract infections with presence of supra-pubic catheter (a catheter placed through the lower abdomen into the bladder to continuously empty the bladder). R2's Service Plan dated April 5, 2024, included medication administration. On June 4, 2024, at 9:07 a.m. HM-C prepared and administered R2's morning medications. R2's signed medication orders dated May 3, 2024, included four medications for mood/behavior, one for acid reflux, one blood thinner, one for recurrent bladder infections, one for seizure disorder, one for cholesterol, and six supplements. R2's MAR dated May 2024, indicated R2 received the following: -venlafaxine extended release 150 mg, one capsule at 9:00 a.m. -Vitamin D3 1000 units, one tablet at 9:00 a.m. -pantoprazole 40 mg, one tablet at 9:00 a.m. -aspirin 81 mg, one tablet at 9:00 a.m. -nitrofurantoin 100 mg, one capsule at 9:00 a.m. -levetiracetam 1000 mg, one tablet at 9:00 a.m. -calcium carbonate 600 mg, one tablet at 9:00 a.m. and 8:00 p.m. -B complex (no dose), one capsule at 9:00 a.m. -multivitamin one tablet at 9:00 a.m. -clozapine 25 mg, three tablets at 9:00 a.m. -Turmeric plus black pepper extract 500 mg, one capsule at 9:00 a.m.	01760			

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01760	Continued From page 36 -cranberry 200 mg, two capsules at 9:00 a.m. and 8:00 p.m. -olanzapine 10 mg, one tablet at 8:00 p.m. -atorvastatin 40 mg, one tablet at 8:00 p.m. -clozapine 100 mg, three tablets at 8:00 p.m. R1 and R2's MARs lacked the required content to include the route of administration for medications and lacked the staff title associated with medications that staff administered. On June 4, 2024, at 1:30 p.m. clinical nurse supervisor (CNS)-B indicated R1 and R2's MARs did not include the required content of the route of medications administered and lacked the staff titles for staff who administered medications. The licensee's Medication and Treatment Documentation and Refusal policy dated June 2021, indicated the following must be documented in the resident's medication and/or treatment/therapy records after providing medication assistance or administration: -the method of administration of all prescribed legend and over the counter medications and or treatments/therapy -signature and title of the authorized person who provided the assistance and/or administration of medications/treatment/therapy - a signature page must be filled out if using initials for verification. The signature page will include name, initials, title, and signature. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	01760			

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01770	Continued From page 37	01770			
01770 SS=D	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure documentation of medication setup included the required content for one of one resident (R2). 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: During the entrance conference on June 3, 2024, at 10:20 a.m. licensed assisted living director (LALD)-A stated the licensee provided medication management services to their residents, including medication setup. R2's Service Plan dated April 5, 2024, indicated she received the service of medication administration and medication set up. R2's signed medication orders dated May 3, 2024, included four medications for	01770			

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NAME OF PROVIDER OR SUPPLIER PRIME TIME ESSENTIAL CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3870 EASTWOOD ROAD SOUTHEAST ROCHESTER, MN 55904		
(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
01770	Continued From page 38 mood/behavior, one for acid reflux, one blood thinner, one for recurrent bladder infections, one for seizure disorder, one for cholesterol, and six supplements. On June 4, 2024, at 9:07 a.m. house manager (HM)-C was observed to set up R2's morning medications for administration. HM-C obtained a pharmacy prepackaged set of medications and supplements found in a med minder (flip top daily medication container). HM-C stated clinical nurse supervisor (CNS)-B came every Friday to set up two capsules of cranberry (supplement) and one capsule of Turmeric plus black pepper extract (supplement) in R2's med minders. The surveyor observed a morning med minder and evening med minder. HM-C documented her administration of the medications on the medication administration record (MAR). HM-C stated she was not aware of how CNS-B documented the medication set up he completed for the med minders. R2's record lacked documentation by the licensed nurse at the time of setup to include the name of medication, quantity of dose, times to be administered, and route of administration. On June 4, 2024, at 1:45 p.m. CNS-B stated he had not documented the medications he had set up for R2. The licensee's Medication Management-Dosage Box set up policy dated August 1, 2021, indicated, a licensed nurse at [Name of AL] will set up resident dosage boxes timely and accurately. When the licensed nurse has completed setting up the medications into the dosage box, the set-up is documented on the MAR.	01770			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40089	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/05/2024
NAME OF PROVIDER OR SUPPLIER PRIME TIME ESSENTIAL CARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 3870 EASTWOOD ROAD SOUTHEAST ROCHESTER, MN 55904			
(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
01770	Continued From page 39 No further information was provided. TIME PERIOD TO CORRECT: Seven (7) Days	01770			

Type: Full
Date: 06/03/24
Time: 16:02:23
Report: 7962241085

Food and Beverage Establishment Inspection Report

Page 1

Location:

Primetime Living
211 1st Street Ne
Rochester, MN55906
Olmsted County, 55

Establishment Info:

ID #: 0037704
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 5072585071
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.

3-500B Microbial Control: hot and cold holding**3-501.16A2 ** Priority 1 ****

MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.

CARROTS 64 DEGREES, DATED 6/2, DISCARDED

Comply By: 06/03/24

5-200A Plumbing: approved materials/design**5-201.11A ** Priority 1 ****

MN Rule 4626.1040A Provide a plumbing system that is designed, constructed, installed, and repaired with approved materials, equipment, and devices complying with chapter 4714 and Minnesota Statutes, sections 326B.43 to 326B.49.

MOP SINK, WATER SUPPLY AND SEWER LINE ARE NOT SECURED TO WALL, DETERMINE IF CORRECTION IS REQUIRED AND REPAIR IF NEEDED

Comply By: 06/03/24

4-300 Equipment Numbers and Capacities**4-302.12B ** Priority 2 ****

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

FOOD THERMOMETERS NOT SMALL DIAMETER

Comply By: 06/03/24

Type: Full
Date: 06/03/24
Time: 16:02:23
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Primetime Living

Food and Beverage Establishment Inspection Report

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5-200C Plumbing: Maintenance, fixture location

5-205.11AB ** Priority 2 **

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

HAND WASH STATION LOCATED IN RESTROOM, MOVE SOAP AND DISPOSABLE TOWELS TO KITCHEN, DESIGNATE ONE BASIN OF TWO COMPARTMENT SINK AS HAND WASHING ONLY AND THE OTHER BASIN FOOD PREPARATION ONLY

Comply By: 06/03/24

2-100 Supervision

2-102.12AMN

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

NO CERTIFIED FOOD PROTECTION MANAGER (CFPM) ON STAFF, SERVESAFE CERTIFICATE EXPIRES OCTOMBER 2025, STAFF TAKE COURSE AND SUBMIT SERVSAFE PASSING CERTIFICATE AND CFPM APPLICATION SENT WIT REPORT

Comply By: 06/03/24

4-200 Equipment Design and Construction

4-201.11GMN

MN Rule 4626.0506G Discontinue serving TCS foods that are held for more than same-day service in an adult or child care center or boarding establishment or provide equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.

CONTAINER OF CARROTS, 64 DEGREES & CONTAINER OF PEAS, DATED 6/2, BOTH DISCARDED. PER OPERATOR NO FOOD IS SAVED OVER NIGHT

Comply By: 06/03/24

Food and Equipment Temperatures

Process/Item: Domestic Refrigerator

Temperature: 64 Degrees Fahrenheit - Location: carrots, dated 6/2, discarded

Violation Issued: Yes

Process/Item: Domestic Refrigerator

Temperature: 38 Degrees Fahrenheit - Location: cottage cheese

Violation Issued: No

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

Establishment Info:

Email reports to:
primetimecare@gmail.com

Type: Full
Date: 06/03/24
Time: 16:02:23
Report: 7962241085
Primetime Living

Food and Beverage Establishment Inspection Report

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

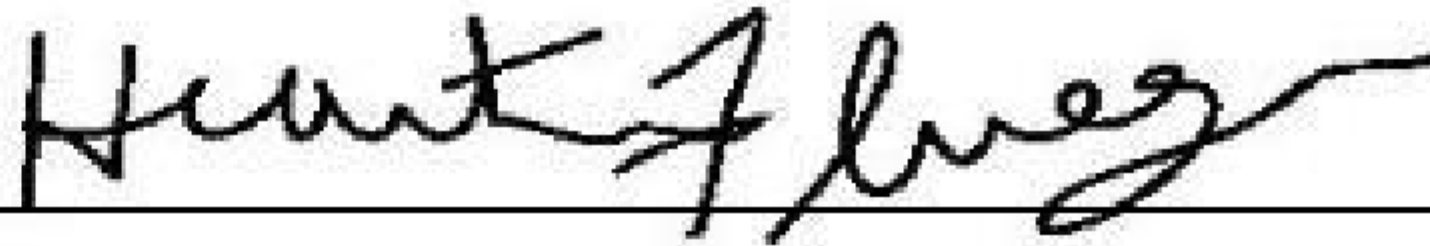
I acknowledge receipt of the Minnesota Department of Health inspection report number 7962241085 of 06/03/24.

Certified Food Protection Manager: _____

Certification Number: _____ Expires: ____ / ____ / ____

Inspection report reviewed with person in charge and emailed.

Signed: _____
Establishment Representative

Signed:  _____
Heather Flueger
Public Health Sanitarian
Rochester District Office
507-208-3096
heather.flueger@state.mn.us